SOCIAL WORK SERVICES OFFERED BY NON-GOVERNMENTAL ORGANISATIONSTO HOUSEHOLDS AFFECTED BY HIV AND AIDS

by

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DECLARATION

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ABSTRACT

South Africa is currently experiencing the highest burden of HIV and Aids globally with an increasing number of new infections, which have a devastating effect on family life. The South African government in collaboration with various stakeholders has developed suitable policies, legislation and strategies to deal with the consequences of HIV and Aids for all South Africans, which include families and children affected by HIV and Aids.

The ecological perspective was used as the theoretical framework for this study to investigate the social worker services rendered by non-governmental organisations to HIV affected households in the Cape Metropole. The goal of the study was to gain an understanding of social work services rendered to HIV affected households by NGOs.

A qualitative research approach was applied, and an exploratory and descriptive research design was used. Semi-structured interviews were conducted with 21 participants who are service providers employed at NGOs that render services to HIV-affected households. These service providers were selected through purposive sampling. Data analysis was guided by the eight-step approach promoted by Tesch (1990) in Creswell (2014) to identify relevant themes, sub-themes and categories.

Findings of the study revealed that service providers employed by NGOs render social work services to HIV-affected households living in poverty restricted areas; hence all NGOs indicated that their mission is poverty alleviation. It was also evident that all social work services rendered by NGOs are guided by policies and legislation such as the White Paper for Social Work (1997), the Social Assistance Act No. 13 (2004) and The White Paper for Families in South Africa (2012), all relevant to alleviating the consequences of HIV for children and families. The findings allowed the researcher to make appropriate recommendations for NGOs to improve social work services rendered to this vulnerable group.

OPSOMMING

Suid-Afrika het tans die swaarste MIV- en-vigslas ter wêreld en ’n toenemende aantal nuwe infeksies het ’n verwoestende uitwerking op gesinne. Die Suid-Afrikaanse regering het gepaste beleide, wetgewing en strategieë in samewerking met verskeie belanghebbendes ontwikkel om die gevolge van MIV en vigs vir alle Suid-Afrikaners, waaronder gesinne en kinders wat deur hierdie siekte geraak word, die hoof te bied.

Hierdie studie het die ekologiese perspektief as ’n teoretiese raamwerk gebruik om ondersoek in te stel na maatskaplike werk wat onder MIV-geaffekteerde huishoudings in die Kaapse metropool via organisasies sonder winsoogmerk (sogenaamde “NROs”) gelewer word. Die doel was om ’n begrip van NROs se maatskaplike werk dienste aan MIV-geaffekteerde huishoudings te verkry.

’n Kwalitatiewe navorsingsbenadering is gevolg en ’n verkennende en beskrywende navorsingsontwerp is gebruik. Semigestruktureerde onderhoude is gevoer met 21 diensverskaffers van NROs wat MIV-geaffekteerde huishoudings bedien. Die diensverskaffers is deur doelbewuste steekproefneming gekies. Vir dataontleding is daar op die agtledige benadering van Tesch (1990) in Creswell (2014) besluit om tersaaklike temas, subtemas en kategorieë te identifiseer.

Die studie bevind dat NRO-diensverskaffers maatskaplike werk dienste aan MIV-geaffekteerde huishoudings in armoedegeteisterde gebiede lewer. Derhalwe het alle NROs hulle missie as armoedeverligting aangedui. Alle NROs blyk ook hulle maatskaplike werk dienste ingevolge beleide en wetgewing soos die Witskrif vir Maatskaplike Welsyn (1997), die Wet op Maatskaplike Bystand 13 van 2004 en die Witskrif op Gesinne in Suid-Afrika (2013) te lewer, wat alles tersaaklik is om die gevolge van MIV vir kinders en gesinne te verlig. Op grond van hierdie bevindinge sluit die navorser die studie af deur toepaslike aanbevelings te doen oor hoe NROs hulle maatskaplike werk dienste aan hierdie kwesbare groep kan verbeter.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
CD4	Count is a test that measures how strong your immune system is
CICT	Client-Initiated Counselling and Testing
CPD	Continuous Professional Development
DSD	Department of Social Development
FSWS	Framework for Social Welfare Services
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency virus
ISDM	Integrated Service Delivery Mode
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
NSP	HIV and AIDS and STI National Strategic Plan
PICT	Provider-Initiated Counselling and Testing
PMTCT	Prevention-of-Mother to Child Transmission
SACSSP	South African Council for Social Services Professions
STI	Sexually Transmitted Diseases
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC	United Nations Convention on the Rights of the Child
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WPSW	White Paper for Social Welfare

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CHAPTER 1:

INTRODUCTION

1.1 RATIONALE OF THE STUDY

The rationale of the study was informed by the prevalence of HIV and Aids in South Africa and its consequences for affected households and for government and non-governmental organisations (NGOs). NGOs in South Africa have played a key role in prevention, care, support and treatment of people living with HIV and Aids despite government's apparent lack of awareness, apathy and attention in dealing with this serious phenomenon in the community (De Wet, 2003:16-17; Rohleder, Swartz, Kalichman & Simbayi, 2009:123-124).

1.1.1 The prevalence of HIV and Aids in South Africa and the consequences for affected households

The global prevalence of HIV and Aids as recorded by UNAIDS (2013:3) reveals that an estimated 35.3 million people were living with HIV and Aids in 2012. In this context South Africa has the highest incidence globally, with an estimated 6 million people living with HIV and Aids in 2012. In the same year 420 000 new infections and approximately 3 600 000 cases were registered (UNAIDS, 2013:A115-127). HIV and Aids have a devastating effect on family life leading to an estimated 410 000 HIV-positive children and 2.5 million Aids orphans. Most of these children were infected by their mothers during pregnancy, childbirth or breastfeeding. South Africa's midyear population estimates reveal that females of all population groups constitute the highest number of HIV and Aids carriers as compared to men; every hour 50 young women are newly infected with HIV (www.statssa.gov.za/publication/statsdownload.asp?PPN=p0302, 2011:1).

In addition, UNAIDS-AIDS by Numbers (2013:1) revealed that 3.4 million women died of HIV and Aids in 2012. It is clear from the above statistics that HIV/Aids have caused immense suffering to children and families with the most obvious effect being illness and death. Children normally remain behind to be cared for by other siblings and families. Children orphaned by and affected by HIV/Aids are normally without protective family care, come from poor backgrounds and are malnourished, as well as lacking shelter, education and health care services (Foster, Levine & Williamson, 2005:93). These children often have to face challenges due to their parent's illness or death, experience psychosocial distress and are at risk of isolation

from family and peer groups, abuse, discrimination and stigmatization (Haihambo, 2004:4). Pharoah (2004:25-26) is of the opinion that children living in HIV and Aids-affected households become vulnerable and needy long before their parents die; they are at risk in terms of their health and welfare when their parents become ill and unable to work. Consequently, the children have to drop out of school, often becoming primary care givers and being responsible for younger siblings. The whole family therefore requires HIV treatment and support from various service providers in the fields of health, social work and education (Pharoah, 2004:79). Authors Vranda and Mothi (2013:20) and Cluver, Gardner and Operorio (2008:363) report that the impact of HIV and Aids may lead to emotional and behavioural problems in the household normally caused by environmental experiences in addition to illness and treatment. These emotional challenges, in addition, are normally not dealt with appropriately by the family and tend to become worse as family members grow into their young adult years.

1.1.2 Government response and legislation

In an effort to move away from a discriminatory, residual welfare approach, the new South African government since the first democratic election in April 1994, has called on all sectors to amend their policies and approaches from a welfare approach to a developmental approach (Gray, 2006:s56). In addition to government, various role players, political parties, trade unions, the business sector, NGOs, civic associations, faith-based organisations and others have played a crucial role in the development of legislation and policies to fit the new political dispensation in South Africa (Zungu-Dirwayi, Shisana, Masala & Seager, 2004:28). Consequently, the following government policies and legislation which were designed for the post-apartheid context, guide social welfare services for children and families affected by HIV and Aids.

The Constitution of the Republic of South Africa (1996:12) includes a Bill of Rights which lists basic human rights that apply to all citizens and also to those living with HIV and Aids. In the context of a developmental paradigm, **The White Paper for Social Welfare** (1997:10-11) recommends an integrated and comprehensive system of social service facilities, programmes and social security to promote social development, social justice and the social functioning of people. This includes support for non-discriminatory services to all HIV/Aids-infected people and families at all levels. **The Department of Social Development** is constitutionally responsible for the emotional, psychosocial and financial care of those made vulnerable by HIV

and Aids and provides social services to alleviate the impact of the disease (Department of Social Development, 2005a:7).

In addition, **The Integrated Service Delivery Mode**l (RSA, 2006:26-28) requires that integrated social welfare services, social security and development services aiming at prevention, intervention, reconstruction and aftercare should be rendered to vulnerable people **The Social Assistance Act No**. **13 of 2004** and the **Security Agency Act No**. **9 of 2004** also affirm the right of all South African children to receive payment of social grants and that these services need to be administered and managed to assure effective service rendering to all South Africans. **The HIV and AIDS and STI National Strategic Plan (NSP)** initially implemented in 2000-2005 was followed by the recent **NSP** of 2007-2011 to address HIV and Aids owing to its high incidence in South Africa. This plan focuses on treatment, care and support with the aim to reduce mortality and morbidity and to increase access to antiretroviral treatment and psychosocial support. In March 2003 the South African government made antiretroviral treatment available to all South Africans who need it and also provided treatment guidelines or protocol for both children and adults (Shung-King, 2004:16).

The Children's Act No. **38 of 2005** is a legal document, with regulations aiming to protect and prevent children from physical, emotional and mental abuse, as well as giving parents, care givers and legal guardians the same responsibility, namely to protect, support and care for the child with specific focus on the best interests of the child (Budlender, Proudlock & Jamieson, 2008:21). As indicated the effective implementation of these policies heavily relies on the involvement of various organisations such as NGOs. The continuous increase in the number of deaths, new infections and illness caused by HIV and Aids, as well as the South African government's initial reluctance to respond to the epidemic, resulted in many NGOs taking the lead in addressing the HIV and Aids crisis in South Africa.

1.1.3 Non-governmental response

Various authors (Cabassi, 2004:17; Lewis, 2007:139; Wallace, Bornstein & Chapman, 2007:19-20) have noted that NGOs in South Africa and many other parts of Africa have been at the forefront in tackling the HIV and Aids epidemic, and also heavily depend on community-based organisations and religious groups for the provision of social welfare services. De Wet (2003:17-18) noted that many NGOs have been established to address HIV and Aids in South Africa and have delivered a variety of services to meet basic human needs such as for food,

health care and shelter, to empower people to better meet their own needs. In 1994, various trade unions and NGOs put much pressure on government to implement laws and policies to protect HIV and Aids sufferers and their families from discrimination and stigmatisation, as well as campaigning for effective treatment, care and support (Gray, 2006:s57; Kauffman & Lindauer, 2004:42-43). It is clear that the care needs of households affected by HIV and Aids are not solely clinical, but also include psychological and social support and protection from discrimination and stigmatisation.

Social workers in NGOs render services to both rural and urban populations who experience poverty, normally have big families, no or low income, limited food, low education, suffer from ill health and experience discrimination (Claiborne, 2004:208). Foster et al. (2005:265-269) confirm that direct services by NGOs to HIV and Aids-infected people include providing food, material assistance and health services. Providing housing and paying school fees are services normally rendered by NGOs. They also play a vital role in ensuring children's safety and supporting affected households. The International Federation of Social Workers (2012:2) identifies the role of the social worker as to educate and support the development and implementation of various programmes such as prevention strategies, treatment, care models, anti-discriminatory policies and research in order to promote the wellbeing of people living with HIV and Aids.

Gavin and Tropman (1998:326) recommend that social work intervention with children and families' needs to focus on micro, meso, and macro levels based on an ecological perspective. This kind of intervention is needed to understand infected and affected children's interaction with their parent/s, sibling/s, within the family and with peers and institutions in society. Lewis (2007:139-143) and Wallace et al. (2007:19-20) summarise the role of NGOs as service providers to those who want, need or seek support and care services that are not delivered or available owing to various reasons, e.g. inequality, poverty and vulnerability, as well as where government services are lacking.

The South African government, as well as various NGOs, have played a vital role in terms of legislation and policies such as the White Paper for Social Welfare (1997) and The Integrated Service Delivery Model (ISDM) (2006) to prevent and protect infected as well as affected households, and alleviate the impact of HIV and Aids on these households. Additionally, the ISDM recommends social welfare and social assistance services that provide protection, care and prevention services through various programmes and workshops aiming at Aids awareness

with regard to children, young people and families, as well as older persons within the family. Also, in order to render continuous optimal services, registered, skilled and knowledgeable service providers are recommended.

Numerous studies have been conducted on the effects on and needs of infected and affected children (Foster et al., 2005:232). One study focused on interventions to support children affected by HIV and Aids with specific focus on orphaned children (Foster et al., 2005:232). Another study done in 2002 in Botswana focused on services needed as well as existing services for orphaned children. This study recommended that the focus should not be on orphans only and that all infected and affected children should be protected from trafficking, sexual abuse, forced prostitution, sexual exploitation, drugs and harmful traditional practices that put children at risk of contracting HIV and Aids (Skinner et al., 2006:23). Modise (2005:1) conducted a study on social work services for children affected by HIV and Aids in rural areas in Pretoria's Kagisana service point. The findings reveal that social workers in NGOs still have much to do to address the needs of children affected by HIV and Aids in rural areas. Harber (2003:62) assessed welfare policy in South Africa and the challenges to family life, poverty, HIV and Aids and orphanhood and concluded that there is a dire need for the development of community-based intervention offered by NGOs with specific focus on vulnerable children and families. Both Nexus and Proquest databases showed the lack of sufficient research on how social workers in NGOs are rendering social work services to HIV and Aids-affected households. This study will therefore aim to fill the gap and to make a contribution with regard to social work services rendered by a selected NGO to HIV and Aids-affected households.

In this study, household refers to those who live together in the same house and who compose a family.

1.2 PROBLEM STATEMENT

HIV and Aids remains a powerful social issue provoking immeasurable stress for both infected and affected children and their families (Abdool Karim & Abdool Karim, 2010:45-51). A substantial amount of research done in South Africa and other African countries is directed at the effects of HIV and Aids on individuals, families, orphans and households headed by children. However, studies focused on the social work services rendered by NGOs to children and families affected by HIV and Aids are limited. Various authors (Richter, Manegold &

Pather, 2004:5) confirm that most of the studies focus exclusively on children orphaned by HIV and Aids and programmes providing services and support directly to those children by NGOs.

The White Paper for Social Welfare (1997:4-8) states that policies and programmes before 1994 were inequitable, inappropriate, and ineffective in addressing poverty, basic human needs and the social development of all people. Thus Nash, Munford and O'Donoghue (2005:52) recommend that social workers dealing with problems related to HIV and Aids in South Africa need to render services and programmes within the social development paradigm which uphold welfare rights, facilitate the meeting of basic needs, build human capacity and participate fully in all spheres of social, economic and political life. Richter et al. (2004:32) recommend social welfare services directed to affected households in South Africa to be based on their psychosocial needs. Despite the political changes in South Africa since 1994, South African society is still characterized by a number of unique social and economic factors such as poverty, continuous ill health, unemployment or undervalued work and little power to induce change. The latter may result in an increased demand for social welfare and health services (Abdool Karim & Abdool Karim, 2010:418). This study will contribute to a better understanding of what social work services are rendered to households affected by HIV and Aids by NGOs within the social development paradigm.

1.3 RESEARCH QUESTION, GOAL AND OBJECTIVES

The study sought to answer the following question: What social work services are rendered by social workers at NGOs to HIV and Aids-affected households?

The goal of the study was to gain an understanding of social work services rendered by social workers in NGOs to households affected by HIV and Aids. To meet the goal of the study the objectives of the study were:

- To explain the phenomenon and consequences of HIV and Aids for affected households and to describe the ecological perspective as theoretical framework for the study.
- To discuss how policies and legislation make provision for social work services to households affected by HIV and Aids.
- To describe the social welfare services mandated by government and rendered by social workers in NGOs to households affected by HIV and Aids.

- To investigate, from an ecological perspective, the nature and extent of social work services rendered by social workers in various NGOs in the Cape Metropole to households affected by HIV and Aids.
- To make recommendations for the promotion of social work services to households affected by HIV and Aids.

1.4 THEORETICAL POINTS OF DEPARTURE

First, the ecological perspective (Germain & Gitterman, 1996) was utilised as a theoretical framework for this study because this perspective focuses on the individual within his/her environment, as well as the transactions between individuals, families, groups and communities (Germain & Gitterman, 1996:26; Teater, 2010:24). Rothman and Germain (1994:42) are of the opinion that the ecological perspective pays attention to the holistic aspect of human beings within a physical environment, society's historic nature, political, economic and social structure, the law and how it influences human development, and behaviour within the different cultural contexts. The ecological perspective provides an opportunity for social workers to assess the reciprocal transactions between families and children and their environment. It therefore enables the social worker to explore the broader context of all the identified social systems as well as the client's social functioning within their environment (Nash et al., 2005:39). Claiborne (2004:208) noted that NGOs and social workers play a vital role in providing social work services and a variety of other welfare activities to the most vulnerable and oppressed members of the population.

Second, the social development paradigm (Midgley, 1995) was explored as the core democratic approach in response to equal, fair and just social welfare service delivery in ensuring the wellbeing of all citizens of South Africa, citing the views of prominent scholars including Gray (2006), Lombard (2008:156) and Midgley and Conley (2010:17). In this part of the discussion reference is made to the White Paper for Social Welfare (1997), The Integrated Service Delivery Model (2006), The Children's Act No. 38 of 2005 and the HIV and AIDS National Strategic Plan (2007) as significant documents directing the transformation of social welfare service delivery in South Africa.

The literature review contributed towards an improved understanding of the social work services rendered by social workers to households affected by HIV and Aids in terms of relevant policies and legislation. Both local and international literature were reviewed.

1.5 RESEARCH METHODOLOGY AND DESIGN

1.5.1 Research approach

The qualitative approach was utilised for the study (D'Cruz & Jones, 2004:60). This approach focuses on the views and perspectives of social workers at NGOs rendering social work services to HIV and Aids-affected households (Fouché & Delport in De Vos, Strydom, Fouché & Delport, 2011:65).

1.5.2 Research design

The study is presented in the form of an exploratory study which allows in-depth analysis of a phenomenon and intends to answer how or why questions, furthermore producing new knowledge (De Vos et al., 2011:321). This design was chosen because exploratory studies are utilised to contribute to our knowledge and learning (Yin, 2009:2). The study involved eight NGOs in the Cape Metropole who offer social work services to children and families affected by HIV and Aids. NGOs usually render social work services to children and families in accordance with The White Paper for Social Welfare (1997) and The Integrated Service Delivery Model (2006). The data that were collected from these NGOs therefore are representative of their social work services rendered to households affected by HIV and Aids in the Cape Metropole.

In addition to the exploratory design, a descriptive design was applied in the study (De Vos et al., 2011:96). As explained, the exploratory design was utilised to gain new insight into social services and activities rendered by social workers in the different NGOs to households affected by HIV and Aids. Within the descriptive design, views of social workers about NGOs response to HIV and Aids was explored and documented (Fouché in De Vos et al., 2011:96; Mouton, 1996:102). The intention of this study was to explore and describe social work services rendered to households affected by HIV and Aids, therefore, the "what" question was utilised to explore and describe the present services rendered to these households.

1.5.3 Sampling

Purposive sampling as a non-probability sampling technique was used (Babbie & Mouton, 2001:166). Qualitative studies utilise non-probability sampling methods, and specifically purposive sampling, which is usually applied in situations where the researcher already knows something about the people or events and deliberately selects particular ones, as they are likely

to produce the most valuable data (De Vos et al., 2011:232).

It was envisaged that the sample size for the study would comprise 21 consenting social workers from the NGOs that would be selected to participate in the study. The sample had to include social workers:

- Rendering social work services to households affected by HIV and Aids;
- Working at a registered NGO within the Cape Metropole that renders social work services to HIV affected households;
- Registered as social workers with the South African Council for Social Services Professions;
- Working in the field of HIV and Aids for at least 1 year.

The researcher has rendered social work services at the Infectious Diseases Clinic of a hospital in the Cape Metropole for the past nineteen years as both practitioner and supervisor. At this clinic she works with managers of non-governmental organisations in parent discussions as well as networking meetings related to infectious diseases. The researcher selected the sample for the study in cooperation with some of these managers.

1.5.4 Method of data collection

The literature study guided the construction of semi-structured interviews in a deductive way, moving from what appeared to be general knowledge to more specific knowledge (Bryman, 2008:9). The semi-structured interviews contained a few close-ended questions while open-ended questions provided participants the opportunity to share their perceptions (Denscombe, 2010:353) (See Annexure D semi-structured interview schedule). Interviews with social workers were audiotaped with the permission of the participants and transcribed by the researcher (Greeff in De Vos et al., 2011:359).

1.5.5 Method of data analysis

Data analysis (De Vos et al., 2011:397) involves the process of making sense of the data to generate patterns and processes, develop meanings and try to understand and explain any contradictions and multiple versions of meaning generated by the participants. Qualitative data analysis involves the development of codes and categories transcribed from the participants'

responses and then organised into themes and sub-themes subsequently presented in the form of narratives (D'Cruz & Jones, 2004:154).

1.5.6 Ethical considerations

Research forms a crucial component of Social Work practice as knowledge is generated through research. This knowledge can challenge existing practices and policies and help to keep the profession up to date by continually improving its services for the good of the public (D'Cruz & Jones, 2004:6). The primary aim is to protect citizens from irresponsible researchers and erroneous information, records and presentation of personal information without written consent (Berg, 1998:36-37). The researcher provided the sampling group with sufficient information concerning the goal of the study, including how the information would be used and why and how they were chosen to participate in the study. This allowed the participants to decide in favour or against participation. The participants were also requested to sign a form to declare that they voluntarily gave consent to participate in the study and for the results of the study to be used as the researcher had indicated (See Annexure C for informed consent forms). To ensure confidentiality, the researcher did not record any personal details of the participants or associate their personal details in any way with the data that were collected. In doing so, the researcher ensured that the anonymity of the participants was safeguarded, thus allowing the participants to participate freely.

In addition to these ethical considerations, the researcher gained official consent from the various NGOs before any interviews were conducted (See Annexure B). This was through explaining the purpose and procedures of the study.

Permission was obtained from the Departmental Ethics Screening Committee (DESC) before the study commenced (See Annexure A). In addition to all these ethical precautions, the researcher is registered with the South African Council for Social Service Professions and is committed to the Code of Ethics of the social work profession. In conclusion: the research was expected to be of minimal risk as defined by the Departmental Ethics Screening Committee (DESC) of Stellenbosch University.

1.5.7 Chapter Layout

The research report is divided into seven chapters:

Chapter 1 includes an introduction and background to the study, together with the research goal, objectives and question.

Chapter 2 describes the research design and methodology.

Chapter 3 explains the phenomenon and consequences of HIV and Aids for affected households and describes the ecological perspective as theoretical framework for the study.

Chapter 4 discusses how policies and legislation make provision for social work services to households affected by HIV and Aids.

Chapter 5 describes social welfare services mandated by government and rendered by social workers at NGOs to households affected by HIV and Aids.

Chapter 6 presents the experiences of social workers in various NGOs in the Cape Metropole in rendering social work services to households affected by HIV and Aids.

Chapter 7 provides a summary, conclusions and recommendations of the study.

A reference list and annexures are provided at the end of the dissertation.

CHAPTER 2:

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter 1 provides an introductory description of the research methodology that was chosen for the study. This chapter aims to describe the methods, processes and plans undertaken by the researcher in order to execute the research study (De Vos et al., 2011:70). Besides De Vos et al. (2011) various authors such as Creswell (2014) and Bryman (2008) have presented views on the most appropriate steps to guide research and this was also taken into consideration.

2.2 RESEARCH PROCESS

For the purpose of this study, the steps of a research process as presented by De Vos et al. (2011:70) which describes the characteristics of qualitative research were followed. These steps are presented in Table 2.1. Each step is discussed below to explain the process followed for this study.

Table 2.1: Qualitative research process

Steps common to the qualitative process	
Phase 1:	**Selection of a reasonable topic**
Step 1:	Identify a researchable problem/question
Phase 2:	**Formal formulations**
Step 2:	Assess suitability of the research approach
Step 3:	Formulate the problem /question/hypothesis/goal and objectives
Step 4:	Draft the research proposal
Step 5:	Consider the ethical implications of the study
Steps unique to the qualitative process	
Phase 3:	**Planning**
Step 6:	Select a paradigm and consider the place of a literature review
Step 7:	Select a research design or strategy
Step 8:	Select method(s) of information collection and analysis
Step 9:	Frame and develop the sample

Phase 4:	**Implementation**
Step 10:	Consider the applicability of the elements of a pilot study
Step 11:	Consider entry and access in implementing the design, collect materials, record, undertake literature study (where applicable)
Phase 5:	**Data analysis, interpretation and presentation**
Step 12:	Process analysed data and verify results. Select additional criteria for judging adequacy
Step 13:	Plan narratives and write the report

Source: De Vos, Strydom, Fouché and Delport (2011:70)

Table 2.1 presents five phases of the qualitative research process while steps to be followed during each phase are illustrated. These phases, as illustrated in Table 2.1, by De Vos et al. (2011) are now discussed in terms of how they were executed in this study.

2.2.1 Phase 1: Select a researchable topic

2.2.1.1 Step 1 - Identify a researchable problem

According to Creswell (2014:149) and Marshall and Rossman (2011:59), selection of a research topic is the first step taken by the prospective researcher in executing research and that it is inspired by curiosity, either from direct experience, career experiences, interest in the real world, as well as identification of gaps in previously conducted research.

The researcher's interest in selecting the current research topic sprung from her years of experience in rendering social work services to HIV-affected households in a hospital setting. The researcher consequently became aware of social work services rendered by various NGOs to HIV-affected households in the Cape Metropole, as indicated in Chapter 1. The researcher furthermore noticed that the research topic was related to various policies and legislation such as the White Paper for Social Welfare (1997) and the Integrated Service Delivery Model (ISDM) (2006) that guides welfare services to HIV-affected households and which aim to prevent and protect infected as well as affected households and alleviate the impact of HIV and Aids on these households.

Additionally the ISDM (2006) recommends the rendering of social welfare and social assistance services that provide protection, care and prevention through various programmes and workshops aiming at Aids awareness with regard to children, young people and families, as well as older persons within the family. In order to render continuous optimal services, registered, skilled and knowledgeable service providers are recommended for this task. The

researcher also became aware that scholars like Cabassi (2004), De Wet (2003) Lewis (2007) and Wallace et al. (2007) have noted that South Africa as a country and many South African NGOs have been in the forefront in addressing the HIV and Aids epidemic through delivering a variety of services to meet the basic human needs of these vulnerable people. All of this stimulated the researcher's interest in investigating the chosen research topic.

The researcher was of the opinion that the research topic was researchable as it arose from her practical experience related to the field of HIV and Aids and gaps identified from previous research that, for instance, focused on intervention and for existing support services for orphaned children (Foster et al., 2005:232), as well as another study that recommended the need to address the needs of affected children (Modise, 2005:1). The researcher therefore embarked on this study to make a contribution to the knowledge base needed to render social work services to HIV affected households (De Vos et al., 2011:80).

2.2.2 Phase 2: Formal formalities

2.2.2.1 Step - Assess suitability of the research approach

This step entailed making a decision as to whether the study would utilise a qualitative, quantitative or mixed methods research approach (De Vos et al., 2011:71). The nature of the study is qualitative and it utilised an exploratory and a descriptive research design (De Vos et al., 2011:96). This is because limited research was conducted on the topic and previous research studies focused on support intervention for orphaned children and existing support services for orphaned children, as explained in Chapter 1. The qualitative research approach therefore was seen as suitable for a study of this nature.

2.2.2.2 Step 3 - Formulation of the research question, goal and objectives

According to De Vos et al. (2011) all research is derived from a thought that the researcher intends to present as a research study or question. Marshall and Rossman (2011:73) recommend that the researcher needs to rely on reading related literature in order to fully refine the proposed topic as well identify gaps on conducted research. These guidelines were followed from the onset of the study. It helped the researcher to redefine the research topic which is presented as: What social work services are rendered by social workers at NGOs to HIV and Aids-affected households?

Furthermore, Mouton 2000 (in De Vos et al., 2011) recommends that the researcher needs to be clear about the goal and objectives of the research because it has to respond to the research question that the researcher is likely to address through the research. The goal of this study as stipulated in Chapter 1 was to contribute to a better understanding of what social work services are rendered to HIV and Aids-affected households by NGOs. In order to achieve this goal, the following objectives were formulated:

- To explain the phenomenon and consequences of HIV and Aids for HIV and Aids-affected households and to describe the ecological perspective as theoretical framework for the study as presented in Chapter 3.
- To discuss how policies and legislation make provision for social work services to households affected by HIV and Aids. This is presented in Chapter 4.
- To describe the social welfare services mandated by government and rendered by social workers in NGOs to households affected by HIV and Aids. This is done in Chapter 5.
- To investigate, from an ecological perspective, the nature and extent of existing social work services rendered by social workers at NGOs in the Cape Metropole to households affected by HIV and Aids. The empirical findings of this investigation are presented in Chapter 6.
- To make recommendations for the rendering of social work services by NGOs to HIV and Aids-affected households. Chapter 7 presents conclusions and recommendations based on the findings of the study.

2.2.2.3 Step 4 - Write the research proposal

The research proposal is the crucial part of presenting the thoughts of the commencing research study. It is a detailed layout of the research plan that involves a working relationship between the researcher and supervisor (Bryman, 2008:67).

The research proposal was finalised and approved by a doctoral admission committee in the Faculty of Arts and Social Sciences in 2014, after which the researcher officially commenced the research study.

2.2.2.4 Step 5 - Consider the ethical implications of the study

Marshall and Rossman (2011:39) explain ethics as a set of ethical guidelines and principles that all researchers should adhere to in order to ensure that research participants are protected from harm, and that the researcher adheres to the ethical rules of the institution.

For this reason, the researcher obtained ethical clearance from the Research Ethics Committee of Stellenbosch University so as to be acquainted with the ethical guidelines of the University (See Annexure A). In addition permission to conduct research at the eight NGOs that were identified was obtained from these NGOs (See Annexure B). Bryman (2008:118) and De Vos et al. (2011:115-120) mentioned that research that reflects good ethical practice needs to avoid harm to the participants by obtaining informed consent and ensuring lack of invasion of privacy and deception of participants (See Annexure C). The researcher addressed these aspects in order to adhere to sound ethical research principles. This is discussed below.

Avoidance of harm to participants

The study that was conducted presented no physical or emotional implications for the participants as the participants, all of whom were social work service providers, only expressed their views and experiences about the social work services rendered to HIV-affected households.

Voluntary participation

The participants initially were telephonically informed about the research study and they gave their consent to participate in the study. They were informed about the actual interview date in order to ascertain voluntary participation before completing the consent form (Annexure C).

Informed consent

After having explained the research study and consent form on the day of the interview, the participants voluntarily signed the consent form, as did the researcher.

Deception

Bryman (2008:124) refers to deception as the researcher presenting his or her research data different from what it actually is.

The participants in this study were not deceived as all information related to the study initially was contained in the letter to the managers at the NGOs which requested permission for the research to be conducted at their NGOs. Thereafter each participant was informed of the day of the scheduled interviews when they were requested to sign the informed consent. Uniform information about the research was given to each participant to avoid conflicting information that could lead to misunderstanding.

Confidentiality

For the purpose of this study confidentiality was maintained through informing the participants that consent forms displaying their names would only be accessed by the supervisor for research quality purposes and therefore would be kept safely by the researcher.

Compensation

The researcher explained to the participants that no participant would be compensated for taking part in the research study, thus requiring the participants to participate voluntarily.

2.2.3 Phase 3: Planning

2.2.3.1 Step 6 – Select a paradigm and consider the place of a literature review

A literature review is essential for providing a context in which to organise the researcher's thoughts about the research question and for the researcher to ensure significance of the research by reviewing existing literature related to the study (Bryman, 2008:81). The following guidelines presented by Bryman (2008:81) assisted the researcher in deciding what to focus on in order to conceptualise and contextualise the study:

- Research conducted previously was read to avoid repetition. The researcher read previous related studies regarding social work services rendered to HIV-affected households and focused on the recommendations made for future research. In so doing the researcher could identify the gaps that led to the current research question.
- Related concepts and theories were explored and used as part of the literature review. As the researcher analysed the transcribed data, themes and categories that emerged were compared to the literature in order to analyse and present the data accordingly.
- Possible research methods and strategies that could be used in the study were identified.

This became evident when the researcher studied the relevant literature that gave rise to the research question, as well as the nature of the study.

- Gaps in existing research were identified and used to formulate the problem statement and research question. After having completed the literature review, the researcher was able to formulate a problem statement and finally decide on a research question.

2.2.3.2 Step 7 - Select a research design or strategy

As indicated in Chapter 1, the study used an exploratory and descriptive design (De Vos et al., 2011:96) as the research concerned the social workers' experiences and views regarding rendering social work services and understanding of existing social work services rendered to HIV-affected households to gain new insight (De Vos et al., 2011:95). The data were collected during face-to-face interviews with the participants.

2.2.3.3 Step 8 - Select a method of information collection and analysis

The researcher therefore followed recommendations by Marshall and Rossman (2011:3) that a researcher who utilises qualitative research should be willing to embark on the following:

- Spending extensive time in the field, to be able to collect rich data;
- Engaging in the complex process of data collection for richness;
- Transcribing the data for evidence;
- Participating in professional social research.

These tasks were performed in this study by the researcher utilising a semi-structured interview schedule to collect the data from 21 consenting social workers who render social work services in eight different NGOs. These interviews were conducted over a period of two months (1 April 2018 – 2 June 2018) until data saturation was reached when information began to be repeated during the last number of interviews. As explained by De Vos et al. (2011:350), the researcher does not learn anything new when this stage is reached. The interviews were transcribed from the recordings made on the site. The researcher found the process of transcribing recorded data lengthy because it required freedom from interruptions because the researcher has to listen to the recordings repeatedly in order to ensure correctness of the transcription. This allowed the researcher to capture thick and rich transcriptions which were utilised as narratives of

participants' views (Marshall & Rossman, 2011:207). The research findings discussed in Chapter 6 serve as evidence.

2.2.2.4 Step 9 - Frame and develop the sample

As suggested by De Vos et al. (2011:232), purposive sampling, was applied for the purpose of this study. This was chosen because the researcher already knew something about the social service providers at NGOs rendering social work services to HIV and Aids-affected households and deliberately selected particular participants from those NGOs as they were more likely to produce appropriate and valuable data. As indicated in Chapter 1, the participants for this study were selected according to the criteria presented below. Participants had to be:

- Employed at registered NGOs that rendered social work services to HIV children and affected households in the Cape Metropole.
- Registered as social workers
- Working in the field of HIV and Aids for at least 1 year.

Twenty-one participants were selected from eight NGOs in the Cape Metropole that rendered social work services to HIV-affected children and households (DSD, 2013). The researcher contacted the Department of Social Development (DSD) and obtained a list of 15 799 registered NGOs in the Western Cape. The researcher had to identify those who were rendering social work services in the Cape Metropole. The researcher then selected the NGOs that were geographically within reach of the researcher. In order to gain permission to conduct the research study the researcher made contact with the manager of each (NGO) telephonically. This was followed up by an email to this manager. After having received feedback from the managers who identified prospective participants, prospective participants were contacted by the researcher and an interview date was scheduled with those who indicated willingness to participate in the research study. Marshall and Rossman (2011:101-102) confirm that getting permission to conduct research requires approaching the organisation's gate keepers. After having made contact with the managers at the eight NGOs, 21 social workers that met the selection criteria were identified.

2.2.4 Phase - 4: Implementation

2.2.4.1 Step 10 - Consider the applicability of the elements of a pilot study

A pilot study is crucial because it allows the researcher to test the feasibility of the study and identifying gaps in the interview schedule and to make adjustments.

According to De Vos et al. (2011:196), the data gathered from the pilot study may be used as part of the findings when a qualitative approach is used. Adjustments were made to the interview schedule to allow for more in-depth exploring of the participants' views and experiences regarding the phenomenon under study (Marshall & Rossman, 2011:95), for example with regard to how the NGOs utilise the funding that they receive to meet the mission of the organisation, and rearranging the questions accordingly. The interview schedule was drafted numerous times before and after the pilot study for adjustments to be made to the schedule. Allowing the researcher to redraft certain questions made it possible to become more specific to be able to obtain more specific concrete views about social work services rendered by NGOs. Marshall and Rossman (2011:63) refer to this process as funnelling.

Semi-structured interviews were conducted with two participants during the pilot study and the data gathered by this means were regarded as part of the study data and analysed . Adjustments were made to the interview schedule as explained.

2.2.4.2 Step 11 - Consider entry and access in implementing the design, collect materials, record and undertake literature study

After gaining access to the NGOs, as described in Step 9, the data collecting process could start. According to De Vos et al. (2011:64) and Marshall and Rossman (2011:92), collecting data in qualitative research often requires in-depth face-to-face interviews with the use of a semi-structured interview schedule.

It is worth noting that questions in the semi-structured interview schedule were developed from the information gained through the literature study. This allowed the researcher to gain insight into the views of participants on the research topic. The semi-structured interview schedule used in this study contained open-ended questions, which was very useful as it allowed the participants to express their views and experiences in rendering social work services (Bryman, 2008:438).

2.2.5 Phase 5: Data analysis, interpretation and presentation and verifying results

The process of data analysis, interpretation and presentation took place after the researcher had already identified the NGOs, selected a sample of participants and the methods of data collection. This process required the researcher to present the various steps taken in order to make sense of the collected data (Creswell, 2009:185; De Vos et al., 2011:403-404). This is discussed in this section.

Creswell (2009:185) offers an overview of the data analysis process as presented below. The researcher followed this process. Each step of the data analysis process is discussed under step 12 below.

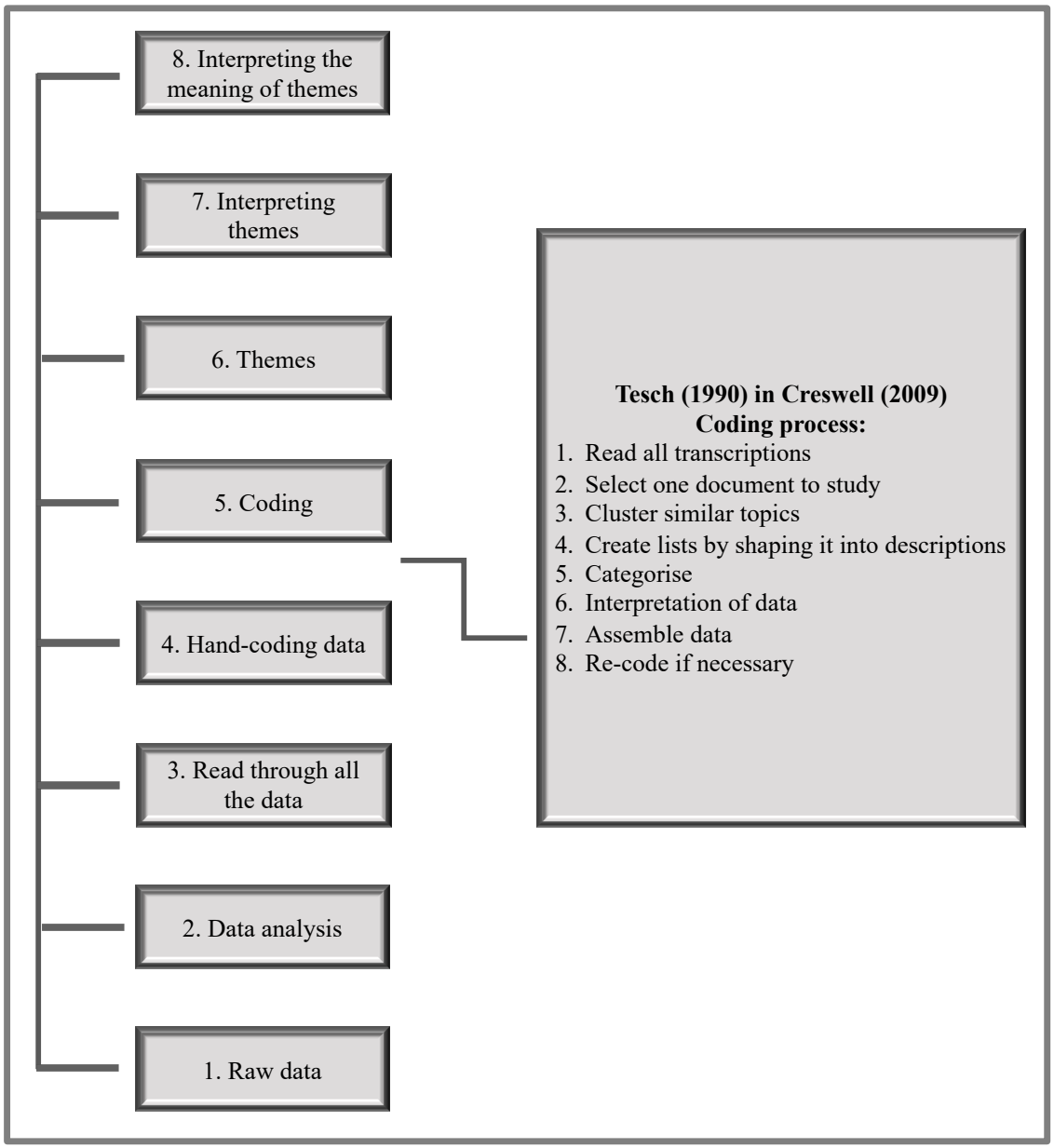

Figure 2.1: Data analysis

Source: Creswell (2009:185)

2.2.5.1 Step 12 - Process analysed data and verify results

At this point the researcher had already collected the **raw data** in the form of digital recordings of the interviews and field notes which were transcribed. It is common in qualitative research to collect a massive amount of data that require to be scrutinized and then to select only what is relevant to the study. This process is referred to as **data analysis,** as the intention is to clean up what seems to be overwhelming and unmanageable (Marshall & Rossman, 2011:210). This was achieved through repeatedly **reading through all the data** for the researcher to become

familiar with the context and to link answers to questions (Marshall et al., 2011:210). It simultaneously allowed the researcher to develop thoughts and ideas about possible themes and categories in relation to the literature review. Creswell (2014) (Table 2.2) refers to this process as coding. Tesch (1990, in Creswell, 2009:186) recommends the use of a hand-coding process. This is discussed below as utilised by the researcher.

- Step 1 entailed carefully reading the transcriptions in order to be able to identify related themes and categories.
- Step 2 required the researcher to select a few transcriptions that contained rich and thicker descriptions of social work services rendered by NGOs to HIV and Aids-affected households. This allowed the researcher to cluster the information.
- Step 3 expected the researcher to cluster similar topics for each section so as to be able to create a holistic picture of not only social work services rendered by NGOs, but also the consequences of HIV and Aids for affected households and what is needed to provide adequate social work services to HIV-affected households.
- Step 4 allowed the researcher to create a list of similar social work services rendered, as well as similar consequences experienced by HIV-infected households as described by the participants.
- Step 5 allowed the researcher to develop categories for similar notions as described by the participants.
- Step 6 required the researcher to make use of the literature review in order to interpret the collected data, to understand the themes and categories identified in relation to the literature and then be able to draw conclusions and recommendations.
- Step 7 expected the researcher to clearly develop themes from the assembled data.
- Step 8 allows re-coding of data. For the purpose of this study, re-coding was not necessary as the themes emerged clearly. The literature study presented in Chapters 3, 4 and 5 made the interpretation and identifying of meaning of the findings possible.

According to Marshall and Rossman (2011:214), themes are the most complex but crucial part of research findings as themes engage the researcher with the collected data. Nine themes emerged in this study. These themes emerged as follows and are discussed in Chapter 6.

- Mission of the organisation
- Sources of funding of NGOs
- Utilisation of funding for services
- Client base of NGOs
- Consequences of HIV and Aids
- Welfare needs
- Prevention and early intervention services
- Statutory, residential and alternative care
- Reconstruction/Reunification and after care services

These themes were divided into sub-themes and categories where applicable. This is confirmed by Creswell (2009:13) as characteristic of qualitative strategies, as also presented in Chapter 6.

2.2.5.1.1 Validating data

Data obtained from qualitative research need to be verified. Validity in qualitative studies refers to checking whether the processes of conducting research are accurate (Bryan, 2008:376). Marshall and Rossman (2011:42-44) recommend the following criteria to ensure the validity of a research study:

Member checking

Member checking or respondent checking is a technique used where the participant is invited to confirm the findings (Bryman, 2008:37). For the purpose of this study, five of the transcripts of the information shared during interviews were returned to five participants at five NGOs to verify that it was a true reflection of the information shared during the interviews. All participants verified the information to be a true reflection of their own contribution with one indicating a correction which was that of naming the NGO. The correction was made, and the participant's confirmation was attained.

Use of thick description

Bryman (2008:378) explains that a thick description of rich data is usually collected from participants in qualitative studies. This also applies to the current study as is evident in Chapter

6. The themes, sub-themes and categories were developed from the narratives that emerged from the data analysis, as already discussed.

Reflexivity

Bryman (2008:698) and De Vos et al. (2005:363) refer to reflexivity as the researcher's involvement in the research process as well as to the importance of the end result with regard to how the research is contributing to the social world. This has relevance to the study as the researcher chose the topic based on her experience in working within the field of HIV and Aids, as well as currently rendering supervisory services to social workers in a hospital setting serving HIV and Aids families.

The researcher had the opportunity to conduct the interviews at the offices of the eight NGOs identified in the Cape Metropole, and therefore was able to observe the geographic area, the service providers, as well as the client base of these NGOs. These NGOs are all situated within communities and are easily accessible to the client base. All these communities are impoverished with mainly children and women accessing these services.

The researcher needed to be very aware of her current role as a researcher and not a service provider as her biases could have conflicted with the views of the participants and result in misdirecting of her role as a researcher. The researched had to be mindful of her current role and that was successfully achieved as the researcher managed to gather the required data.

With black South African women having consistently experienced poverty and gender inequality in South Africa, it is disturbing to see that, even after 25 years of democracy, people are still living in dire poverty and that there are still new HIV infections despite the availability of anti-retroviral treatment (ART) This raises concerns about the feasibility of programmes that are utilised by NGOs to prevent HIV transmission as well as to alleviate poverty.

Credibility

Validity of a study is based on its credibility. According to Marshall and Rossman (2011:346) and De Vos et al. (2011:250), credibility refers to the manner in which the study is conducted in order to ensure that the research topic is appropriately identified and described. The credibility is evident from the goal of this study which was to explore social work services rendered by NGOs to HIV-affected households in order to make recommendations for the promotion of social work services to households affected by HIV and Aids.

De Vos et al. (2011:346) furthermore are of the opinion that research becomes valid or trustworthy when the participants are assured anonymity to participate willingly.

For the purpose of this study, each participant was given the opportunity to voluntarily participate and informed that the study would ensure anonymity. These allowed participants to be honest and divulge truthful information (see Annexure C). In addition, rich data were collected, resulting in a thick description which illustrates the complexity of the study, as indicated in Chapter 6. The data were analysed and presented with continuous reference to the literature to compare the findings of the study with existing literature and it was further guided by the theoretical framework discussed in Chapter 5. It is evident that well-established research was employed in order to ensure credibility (De Vos et al., 2011:346). As explained, member checks were also done to ensure validity.

Transferability

Transferability concerns the ability of the researcher to prove that the study will be useful in other similar situations (Creswell, 2007:208). De Vos et al. (2011:346) confirm that the researcher may design the study for a small group or individuals sharing the same characteristics in order to strengthen transferability or use more than one data collection method in order to gather thick data so as to generate the possibility of transference to other social settings.

This study itself proves its transferability as the research processes were clearly followed during the study. The research process was followed from the onset, starting with the idea, the actual topic, how the participants were selected, as well as how the researcher gained access to the participants. The interviewing processes, the use of a semi-structured interview schedule, as well as the process of data analysis and presentation were also in line with requirements for transferability.

Dependability

Dependability refers to the phases of the research process followed by the researcher in executing the research study, which entail selecting the topic, selecting the participants, writing field notes, transcribing interviews, and data analysis that is evidence-based in order to ensure trustworthiness (Bryman, 2008:378).

The research design and implementation of the study are illustrated in parts of this chapter. The details of data collection as described by De Vos et al. (2011) were followed by the researcher, as evident in the current chapter. The transcribed interviews were also submitted to the research study supervisor. The researcher clearly stipulated the reflexivity of the study by the researcher indicating the benefits of the study to the social world.

Conformability

According to Marshall et al. (2011:253), conformability refers to the researcher's ability to complete a research study that can be evaluated by someone else without the insight of the researcher; this proves accuracy of the research study. De Vos et al. (2011:347) furthermore argue that the research study should provide detailed methodological descriptions that ensure validity. The 13 steps of research as described by De Vos et al. (2011) are presented in this chapter. Chapter 6 presents the findings of the study, providing direct quotes from the participants derived from the rich data collected. This led to the emergence of themes and categories and followed by conclusions and recommendations of the study as presented in Chapter 7. Five participants were given the opportunity to confirm that the transcriptions are a true reflection of the interviews.

2.2.5.2 Step 13 - Plan narratives and write the research report

The writing of the research report is the final step in the research process. It presents the results of the findings of the research study to the world (De Vos et al., 2011:247). Marshall et al. (2011:222) noted that the writing of a research report entails the initial thought of a prospective research study, the research processes and the final stage of the findings and recommendations. Qualitative research report writing is complicated due to the vast data collected. Therefore it required the researcher to be engaged in interpreting the data, lead and shape the data so to form or develop meaning to the mountains of data gathered. The researcher found this process complicated and ambiguous as it required constant reviewing of the literature and the data so to be able to identify themes and select related narratives from the data in order to develop insight into the results of the study.

2.3 CONCLUSION

The researcher explained the journey of the research study based on the guidelines presented by De Vos (2011) for executing a qualitative research process. These phases started from an idea that led to the selection of a researchable topic which involved numerous discussions with the supervisor. This was followed by the formalities of deciding which methods and designs to implement. Then the formal writing of the proposal followed. This was later presented to a doctoral research admission committee for approval. When approval was granted, the data collection process and analysis which followed led to the final research report. Because of the latter the researcher has a clear understanding of social work services rendered to HIV affected households.

CHAPTER 3:

THE PHENOMENON AND CONSEQUENCES OF HIV AND AIDS FOR SOUTH AFRICAN HOUSEHOLDS AND AN ECOLOGICAL PERSPECTIVE

3.1 INTRODUCTION

AIDS (acquired immune deficiency syndrome) is caused by HIV (human immune deficiency virus) which is the early stage of the disease that is later characterised by severe opportunistic infections and diseases that define AIDS and may lead to the death of a person (Van Dyk, 2008:40). Children can be infected or affected by adults who are HIV positive. The consequences of the adult's infection may lead to material problems, poverty, food insecurity and lack of access to education, health and welfare services for their households (Rohleder et al., 2009:70) Consequently, infected children may face double effects as they have to go through the physical effects caused by the opportunistic infections, as well as going through the trauma related to their own illness and death (Mallman, 2002:15).

The effects of the HIV/Aids epidemic on households are massive and will remain so for decades. In 2012 as many as 250 000 children between 0 and 17 years had been orphaned by HIV and Aids and 15 000 child-headed households existed due to HIV and Aids (UNAIDS, 2012:1). The HIV and Aids pandemic not only threatens to the physical health and survival of millions of affected households and children. It is destroying their families and depriving them from parental love, care and protection (Richter et al., 2004:8-9). In addition, affected households may experience economic hardship, personal trauma, psychosocial and psychological effects due to emotional deprivation caused by the death of a sick parent (Gow & Desmond, 2002:97). As a result, the HIV and Aids epidemic has affected every aspect of the life of infected and affected households in South Africa., It therefore is of vital importance to understand the modes of HIV transmission and the various consequences of HIV and Aids for affected households to gain a better understanding of the phenomenon and its consequences in South Africa.

This chapter addresses the first objective of the study, which is to explain the phenomenon and consequences of HIV and Aids for affected households and to describe the ecological perspective as theoretical framework for the study. In doing so, a brief description of the phenomenon of HIV and Aids, HIV transmission in general, HIV transmission to children, and

risk factors associated with HIV infection in children is presented. This is followed by a discussion of the consequences of HIV and Aids for children and households. Finally, a discussion on the ecological perspective, the chosen theoretical framework for the study, is presented. How this theoretical framework can guide social workers in how to offer the care and support needed by HIV and Aids-affected children and households is explained.

3.2 DESCRIPTION OF HIV AND AIDS

AIDS is the abbreviation for Acquired Immune Deficiency Syndrome, which is caused by the human immune deficiency virus (HIV), the early stage of the disease that is later characterised by severe opportunistic infections and diseases that define AIDS and may lead to the death of a person (Van Dyk, 2008:40).

3.3 MODES OF TRANSMISSION

In seeking to understand the phenomenon and consequences of HIV for affected households and to be able to utilise relevant policies, legislation and programmes that could alleviate these consequences, it is essential for social workers at NGOs to understand the various modes of HIV transmission. Page, Louw and Pakkiri (2006:128) and Anderson (2000:13) describe four major categories of HIV transmission, Aggleton, Hart and Davies (1999:206) similarly confirmed that there usually are four proven categories for HIV transmission. The four modes of transmission are briefly discussed below.

3.3.1 Transmission through blood and indirect components or derivatives of blood

According to Van Dyk (2005:214), the most common means of transmission of HIV is via contact with infected blood, semen or cervical/vaginal fluids. Consequently, HIV can be transmitted from an infected person to his or her sexual partner, through man-to-woman, man-to-man, woman-to-man or woman-to-woman contact. Another mode of transmission commonly occurs through sharing hypodermic needles with an infected person. This is most evident in people who inject drugs like heroin. Some transmission also occurs as a result of the transfusion of blood and blood products, for example by the re-use of contaminated needles and needle-prick injuries, which is most evident in health care sectors. However, Anderson (2000:3) noted that this form has a low infection rate as less than 0.1 percent of such events have resulted in infection with HIV Equally important is Davey and Seale's (2004:101) submission that health workers may also be exposed to infected blood or other body fluids when splashed in the

eyes, nose and mouth while performing surgery. The rate of this kind of infection is under three percent, however.

3.3.2 Transmission through semen, vaginal and cervical secretions during intercourse

The next mode of transmission is due to the presence of HIV in blood and semen, which indicates the primary form of sexually transmitted infection. As vaginal or anal intercourse results in close contact during penetration, the transmission risk is very high, even when precautions are taken. This is due to tears, lesions and rips that regularly occur during intercourse. Evian (1993:12) points out that receptive rectal and vaginal sexual intercourse present the greatest risk of infection, namely from 0.1 to 3 percent. Condoms that are used, for instance, sometimes break or come off. In contrast, there is little evidence regarding unprotected oral sex and to what extent the low concentration of HIV particles in saliva, urine, and vaginal secretions constitute a possible source of transmission. It is notwithstanding recommended that condoms be used or oral sex be avoided if there are lesions in the mouth (Davey & Seale, 2004:101). It is worth noting that Temoshok and Baum (1990:68) refer to these modes of transmission as horizontal transmission, as infection is passed between individuals during certain risk behaviours.

3.3.3 HIV transmission to children

Another mode of transmission relates to children who may also be infected with or affected by HIV at a very early stage if proper precautions and risk behaviours are not avoided by adults. Thus it is well established that vertical transmission is the most common mode of mother to child transmission. Children in South Africa are the most severely impacted by the HIV and Aids epidemic. According to the Mid-year population Report (2014:1), 48% of children younger than 18 years were living with HIV in South Africa in 2013. Most of these children became infected through mother-to-child transmission (MTCT), as well as through blood, sexual activities and the use of drugs.

In order to explain the phenomenon of HIV and Aids for children, it is important to understand the modes of transmission associated with HIV infection in children. HIV and Aids transmission to children occur in various ways.

3.3.3.1 Transmission through the mother

The first mode of transmission of HIV to children is mother-to-child transmission. The majority of HIV-infected children under the age of 13 years acquire HIV from their infected mothers during pregnancy, at the time of delivery, or after birth through breastfeeding (Stine & Mfusi, 2013:22; Rohleder et al., 2009:184). UNICEF statistics (2014:2) confirm that 90 percent of HIV infection in infants and children occur by vertical transmission. In South Africa 300 000 children are born to HIV-infected mothers each year (UNAIDS, 2013). Finally, the rapid or slow progress of infection in children varies depending on when the child is infected during birth, via sexual abuse, or by blood transfusion. Of importance is that those infected during birth tend to progress very quickly compared to those infected after birth (Citron, Brouillette & Beckett, 2005:182). The following section gives an indication of the risk factors associated with mother-to-child transmission.

3.3.3.1.1 Delivery

A mother who is infected with HIV is more likely to pass on the virus to her baby during delivery and labour as the risk is increased by prolonged rupture of membranes, bleeding and the instruments used to assist in delivery (USAIDS, 2010:2).

3.3.3.1.2 Pregnancy

As explained, an infected mother is more likely to transmit HIV to her fetus during pregnancy or just before delivery. This is influenced by the maternal stage of the disease (Van Dyk, 2005:31), when the viral load is extremely high and the CD4 count very low, which can result in a direct effect on transmission (Abdool Karim & Abdool Karim, 2010:201).

3.3.3.1.3 Breastfeeding

When the mother is already HIV positive, children can become infected during breast feeding or later during pregnancy in the presence of a high viral load and low CD4 count (Abdool Karim & Abdool Karim, 2005:185). In addition, various other factors may contribute to the baby's risk of infection, such as the pattern of breast feeding, the health of the mother's breast, the baby's mouth, the duration of breastfeeding and the mother's sexual behaviour (Van Dyk, 2012:48). Scholars like Abdool Karim and Abdool Karim (2005:189) and Piwoz, Huffman, Lusk, Zehner and O'Gara (2001:2) further mentioned that HIV transmission can occur at any time during breast feeding. A study conducted in South Africa in 2007 revealed that mixed

modes of feeding such as breast and bottle feeding carry a higher risk of HIV infection compared to excluding breastfeeding for at least the first six months. The study further reports that an average of 40 percent of infected children die before they reach the age of five and the remainder may live in severe poor environments and most likely could become vulnerable to abuse, neglect, and exploitation (Uchendu, Ikefuna & Emodi, 2009:14).

3.3.3.2 Transmission through blood

The second mode of HIV transmission to children is through blood-borne transmission. This form of transmission normally takes place in hospital settings. Damani (2003:185) noted that HIV transmission through blood can occur via needles other blood contaminated sharps, and organ transplantation. People at risk include intravenous drug users, health workers and recipients of blood, blood products and organs. In addition, HIV infection can occur in medical settings through the use of unsterilised needles and blood transfusion where infected blood is used (Damani, 2003:55). With regard to unexplained HIV infection in children, it was reported that 18 cases of infected children whose mothers tested HIV negative were registered in South Africa in October 2014. These mothers presented with a history of multiple hospital admissions. Possible early sexual activities were likely in two cases. The risk factors were found to be exposure through intravenous antibiotics, intravenous access and the possible use of expressed milk for babies (Hiemstra, Rabie, Schaaf, Eley, Cameron, Van Ransburg & Cotton, 2004:189). The British Journal of Obstetrics and Gynecology (2003:250) likewise revealed that the results reporting on risk factors of HIV infection in South Africans aged two years and older published by the Human Sciences Research Council (HSRC) in 2002, confirmed that three quarters of HIV-infected children between the ages 2 and 11 years have been infected through another source than their mother. It is evident that this form of transmission is not confirmed, but as a possible mode of transmission.

3.3.3.3 Transmission through sexual activities

The third mode of HIV transmission to children is through sexual activities. Sexual activities in the context of HIV transmission include sexual abuse, rape and sexual exploitation.

The prevalence of sexual abuse of young children in South Africa is very high. South Africa simultaneously is in the midst of the fastest growing HIV epidemic in the world, although, HIV transmission through sexual abuse does not account for a high proportion of child infection in

South Africa (Richter, Dawes, Higson-Smith, 2005:130; Abdool Karim & Abdool Karim, 2010:203).

The South African Police has raised concerns regarding the alarming prevalence of rape of children, with rape of 5859 children between 0 and 12 years having been reported (html:file//F:/DeadlySouthAfrica's Efforts to prevent HIV in survivors of sexual violence, 2005:1). Because rape or sexual abuse is a violent crime which normally involves organ injuries, fractures, physical injuries which require medical intervention and lead to hospitalization, victims may be expose to contaminated blood products and organs (Naidoo, 2013:1). The South African Medical Journal (2013:1) similarly reported that South Africa has the largest incidence of rape and that 33 percent of children are raped by a teacher, while 21 percent of rapes are committed by perpetrators known to the victim, or relatives of the victim. In addition, a study on strategies for managing teachers with HIV and Aids conducted in South Africa in 2013 revealed that the main drivers of sexual abuse of children by teachers are economical, because parents accept bribes from accused teachers to remain silent (Steyn & Mfusi, 2013:220). Yet Gow and Desmond (2002:67) noted that, despite the high prevalence of rape amongst children and women in South Africa, the extent to which child sexual abuse contributes to HIV infection is not known.

Furthermore, exposure to sexual exploitation and survival sex is another characteristic of street children. Children on the streets normally come from impoverished backgrounds, where income is lower, and run away from home to escape poverty and abuse. They normally are 10 to 12 years old when they begin to live on the streets. In Johannesburg and Pretoria, they begin living on the streets from four years of age (Kruger & Richter, 2003:4). These children are tasked with fending for themselves due to the lack of parental care and protection and by so doing become vulnerable to sexual exploitation, engaging in survival sex at a younger age, and having sex with multiple partners without the use of condoms (Rotheram-Borus, Becker, Koopman & Kaplan, 1991:230). Once these children are infected with HIV, they are prone to poor health due to their living conditions and the fact that they are less likely to seek medical attention. Consequently, this may mean faster progression of HIV into Aids than may be the case when a nutritious diet is followed (Kruger & Richter, 2003:7).

In South Africa the rumour of sleeping with a virgin to cure HIV was based on the expectation of removing physical and ritual dirt. However, no research has confirmed the cleansing myth or the fact that it increases sexual abuse (Richter, Dewese & Higson-Smith, 2005:74).

Additionally, sexual exploitation can be related to myths. Equally important is the lack of safety and protection in households which expose children to the risk of being sexually abused and exploited within the community. Although all children are vulnerable to HIV infection, it is evident that there are certain children who are particularly vulnerable to HIV infection, such as those on the streets, who are using drugs or other substances which lead to risk taking behaviour as well as becoming child sex workers (Abdool Karim & Abdool Karim, 2010:245). Authors like Shisana, Rehle, Simbayi and Mbele (2005:114) reveal that such children become vulnerable and at risk simply because they are born at a time where the prevalence of HIV/AIDS is escalating, as well as that their social background is shaped by poverty so that they are at risk of exposure to early sexual practice, sexual abuse or exploitation due to lack of protection and care.

3.3.4 Transmission through drug use

The fourth mode of HIV transmission is through the use of drugs. In South Africa, needle and syringe use is common practice amongst injecting drug users and poses a high risk for transferring HIV. However, intravenous heroin use in South Africa is very low at present (UNAIDS, 2013:30). Injecting drug use, however, is an important characteristic of children living on the streets, although the extent of intravenous drug use amongst children in South Africa is not known. as well as not having a major intravenous drug use problem in South Africa (Abdool Karim & Abdool Karim, 2010:247).

It is worth noting that the most popular drug used in Cape Town is methamphetamine (TIK). A study conducted in 2008 in the Western Cape shows that 60 percent of children younger than 20 years use methamphetamine (HSRC, 2008:54). The intoxication of TIK use reduces their ability to make sound decisions, their ability to negotiate for safer sex, and the proper use of condoms. Thus they are at greater risk of HIV infection (Foster et al., 2005:192). The following section discusses the consequences of HIV and Aids.

3.4 CONSEQUENCES OF HIV AND AIDS FOR AFFECTED HOUSEHOLDS

Diagnosis with HIV may mean that members of both infected and affected households may face extreme consequences. Such a diagnosis also has physical, emotional, health, economic and welfare consequences. These consequences are described below.

3.4.1 Consequences for households United Nations International Children's Emergency Fund

HIV and Aids affect all children globally, but the impact is greater in South Africa as it is one of the countries with the highest prevalence of HIV and Aids (UNAIDS, 2013:A21). In 2012, the United Nations Children's Emergency Fund (UNICEF, 2010:2) reported global figures indicating 3.3 million children living with HIV; 260 000 new infections amongst children; 210 000 deaths; 17.3 million orphans (with one or both parents having died); and 150 000 children in South Africa believed to be living in child-headed households. However, although child-headed families are common in Africa, it is not so in South Africa. A general household survey in 2006 indicated that only 0.67 percent of children live in child-headed household in South Africa (Meintjes, Hall, Marera & Boulle, 2009:1). Furthermore, an estimated 70.4 percent of maternal deaths in South Africa in 2011 were due to HIV infection, as with children under 5 years (WHO, eliminating mother-to-child transmission in South Africa mht, 2012:11). Abdool Karim and Abdool Karim (2010:380) reveal that the impact of HIV on the family and community starts when a parent, a child or the head of the household becomes infected with HIV or becomes ill with advanced HIV and Aids.

It is worth noting that scholars like Giese (2009:14) and Richter, Manegold and Pather (2004:8) maintain that every child in South Africa could experience the impact of HIV and Aids, whether at birth or later in life. The latter is due to the high number of children born to HIV-infected mothers, as well as the high maternal mortality rate in South Africa. According to Van Dyk (2001:265), children are infected with the HIV virus or may be affected if they do not have the virus but one or both parents are infected with the HIV virus. It became evident that an adult HIV diagnosis in a household affects both infected and non-affected children.

Having said that a household can be affected by HIV and Aids because of the HIV diagnosis of an adult, they can be struck hard by the consequences of HIV and Aids when parents become ill, are unable to work, or are not there to protect their children due to the severity of the illness. The results can disrupt children’s lives and put their health, education, welfare and security at risk (Rohlender et al., 2009:70). Households affected by HIV and Aids are at risk of poor parental involvement in children’s upbringing; role changes; parental absence due to parents being too ill, hospitalisation, or death, resulting in child abuse and neglect (Lachman, Cluver, Boyes, Kuo & Casale, 2014:39). Some of these children, normally the eldest, will take up the

parental role and eventually become the head of the household (Van Dyk, 2008:346). However, HIV and Aids have consequences profound for children at many levels.

3.4.2 Consequences for affected children

Affected children are those children who are not infected with the HIV virus, but whose parents have died due to HIV and Aids and are placed in foster care, are cared for by adult children, or are placed in alternative care (Pharoah, 2004:13). Foster et al. (2005:138) further noted that affected children are those children whose parents, extended or close families, their communities, or the services and structures that exist for their benefit are prohibited by the impact of HIV and Aids.

South Africa remains one of the countries most affected by the HIV and Aids epidemic, with women of productive and parenting age being the most affected (Mid-year population estimates, 2015:6-7). Affected children simultaneously are often cared for by a single mother in an unemployed household as their fathers are often absent (http://www.timeslive.co.za/local/2011/04/04/south-african-family-incrisis-sairr). Whiteside (2008:57) and Operario, Pettifor, Cluver, MacPhail and Ress (2007:93) confirm that women's death in South Africa due to HIV and Aids is the highest in late 20- to 30-year age groups. However, according to these scholars, causes of death are not always disclosed due to reasons like fear of discrimination against children and households that are left behind. Thus children and households of an HIV-deceased person find it difficult to grieve openly due to the stigma and discrimination associated with HIV and Aids. They therefore grieve in secrecy and never fully overcome the pain, which in many instances results in depression (Van Dyk, 2012:314).

The consequences of HIV and Aids that are imposed on affected children are severe. Children born from HIV-positive mothers are vulnerable to abandonment by their mothers due to a variety of issues, e.g. parental fear of being unable to care for the child, being a single parent, illegitimate birth, fear of family break-up, poverty and many more. These children normally end up in various placements in institutions or in care and continue to experience minimal psychosocial support (Foster et al., 2004:150). The toll of HIV and Aids on affected households can be very severe. In many cases the presence of Aids may mean that the household will dissolve, as parents die and children are sent to immediate families or relatives (Abdool Karim & Abdool Karim, 2010:373).

Affected children consequently experience major psychosocial and emotional challenges caused by the conditions in which they are left behind by their mothers, for instance, ill treatment by the carer or her children, burdened with an excessive amount of work and neglect. In addition, they can be exposed to lack of basic needs such as food and education. This can lead to poor progress at school, and deterioration of their health due to lack of proper care. A lack of financial means to properly care and support these children and an inability to care for them due to financial constraints can also be experienced (Van Dyk, 2012:315). Bor and Elford (1998:265) are of the opinion that such experiences result in children doubting their future security and the care that they will receive. In this regard Van Dyk (2012:325) and Elford (1998:265) warn that children go through the same stages of bereavement as adults, and that the fundamental difference is that children's understanding and mourning because of death depends on their developmental stage. This may mean that children associate death with the deceased coming back soon, whereas adults detach from the deceased, adjust and tend to proceed with life. Thus Van Dyk (2012:325) recommends bereavement counselling at an appropriate age (of above ten years) when the child is emotionally and physical comfortable about sharing their grief with an adult person.

It is important to note that parental death resulting from HIV and Aids often occurs at the crucial stage when children need their mother the most for parental guidance. It therefore is fundamental to attend to these children's needs appropriately in terms of providing bereavement counselling to overcome possible future behavioural problems, and emotional and physical loss (Bor & Elford, 1998:265).

3.4.3 Consequences for survival and care

As can be seen, the loss of a parent can have serious consequences for an affected child due to lack of provision for basic needs such as food, shelter, clothing, health care and education. (Abdool Karim & Abdool Karim, 2010:374). Hence family members should move in and out of households or move from different destinations in order to assist in the care of those left behind as the result of the death of a family member. The responsibility of caring for children is normally shifted to family members. This may result in rendering children more vulnerable due to lack of proper supervision, as well as the distress normally caused by separation (Richter et al., 2004:12). The majority of children who have lost a parent continue to live with the surviving parent or another family member. These children then often have to take responsibility for doing the house work, caring for the other siblings and caring for the

remaining, often dying, parent (Abdool Karim & Abdool Karim, 2010:3750; Patenaude, Phipps, Sahler, Sourkes & Reltzer, 2008:20).

It has been observed that these children are normally cared for in single parent households, by grandparents or in child-headed households characterised by financial constraints. This then results in lack of education or early school dropout, lack of a nutritious diet, deteriorating health and severe personal trauma and stress experienced by the affected children due to additional responsibilities (Gow & Desmond, 2002:97). In most instances, the households supporting these children find it difficult to cope with the additional family and siblings' needs that they cannot meet due to financial constraints, unemployment and poverty. This normally leads to stress and trauma associated with caring for the sick. The number of households affected by HIV and Aids is growing drastically and they encounter enormous social and psychological stress which adds to their inability to cope emotionally. This may also result in financial constraints, lack of access to social grants, food insecurity, lack of school attendance and drop out as the family or siblings taking care of the children might be unemployed (Foster et al., 2005:187).

3.4.4 Emotional consequences

The effects of HIV and Aids on children usually are of a physical, emotional, and psychological, as well as socio-economical nature (Deacon & Stephrey, 2007:1). Children are affected differently, however, depending on their ages and also because of suffering the emotional stress of losing a parent or care giver (Skinner et al., 2004:13). As soon as A child born to an HIV positive family or associated with such a family may immediately experience isolation and rejection by their peers, parents and society.

Furthermore, while still living with their parents these children see their parents becoming ill, deteriorating and eventually dying. Awareness of the latter already exposes them to fear, anxiety and grief, because they imagine a future without a parent and looking to other family members and siblings for support. Foster et al. (2005:186) observed that children of HIV-infested parents are more likely to be depressed and tend to misbehave at school and at home. They, for instance, reveal a tendency to bullying, picking up fights, antisocial behaviour, and unexplained headaches, presented by Garry Maartens additionally revealed findings at the 3rd HIV Conference in Durban in 2007 that HIV-affected orphans and vulnerable children experience great distress, depression, peer problems and come into conflict with the law at an

early age (Cluver, Gardner & Operario, 2008:732; Wang, Xiaoming, Bernett, Zhao & Stanton, 2012:1435). Foster et al. (2004:156) asserted that the stigma and discrimination experienced by affected children and their families result in psychological stress due to verbal and physical responses. The psychological effect on these children's may be stigmatization due to their experiences and behaviour.

Of importance is that stigma is one of the most powerful forces that inhibit every effort to combat HIV, as it prohibits people from accessing treatment. People also may hide their relatives or loved ones away from the public due to fear of rejection and judgement (UNAIDS, 2006:12). Stigma and discrimination have been associated with HIV and Aids since the very onset of the epidemic and constitute a challenge to both children and households affected by HIV and Aids may this even get worse as the child grows older (Save the children, 2001:1).

3.4.5 Educational consequences

South Africa has the largest number of new HIV infections amongst children, which consequently means that many are significantly disadvantaged. The South African National HIV prevalence, Incidence and Behaviour Survey (2012:40) highlighted that the prevalence of HIV infection amongst children aged between two and fourteen years has increased from 2.348 percent in 2008 to 8.1 percent in 2012, followed by an increase from 2.099 percent to 8.1 percent amongst 15- to 24-year-old children. This is a clear indication that children at primary, secondary and tertiary school are exposed to a variety of challenges that may result in reducing attendance at school or temporarily or permanently missing out on schooling (Tladi, 2012:370). Those who are fortunate enough to not have these experiences may experience absent educators due to HIV and Aids. This can result in them not receiving adequate education due to the educators' inability to perform their duties (Steyn & Mfusi, 2013:217). The latter might negatively affect human development and the economy of the country as education of children at school will decline (Bialobrzeska, 2007:6).

As observed by authors, discrimination and stigma experienced by affected children can deprive them from socializing with their peers at school and may sometimes lead to poor attendance at school due to ill health (Richter et al., 2004:11). In addition, the loss of a productive family member is likely to result in poverty for the household and consequently increase the chances of children not attending school and lead to early dropout., Preschool children are similarly vulnerable to failing to attend school, early dropout from school, sexual abuse, neglect, lack of

stimulation and vulnerability to nutritional deficiencies (Richter et al., 2004:13). Thus, the school attendance of children in HIV-affected households is often very poor due to a lack of income to cover the child's schooling needs. This then results in early dropout from school in order to assist the family in generating income (Foster et al., 2004:138).

In addition, the neurological effects of progressed HIV may result in developmental delays in children and/or dysfunction which may prevent formal school attendance of these children, or lead to poor progress and early dropout (Rohleder et al., 2009:72). Equally important is that performance in instances where the girl child is still attending school can be poor and become a major challenge due to a combination of household chores and school work. This is because it is expected of the child to leave school to provide care or to make a financial contribution to the declining household income (Booysen, 2009:58).

3.4.6 Health care consequences

South Africa has a young population because in 2013 out 48 percent of the total population of 52 981 991 were younger than 18 years of age (Mid-year population estimates, 2014:1). HIV and Aids simultaneously had a devastating effect on family life because of an estimated 410 000 HIV-positive children and 2.5 million Aids orphans, as mentioned above. Most of these children were infected through vertical transmission.

South Africa's midyear population estimates reveal that females of all population groups constitute the highest number of HIV and Aids carriers compared to men, with 50 young women newly infected with HIV every hour (www.statssa.gov.za/publication/ statsdownload.asp?PPN=p0302,2011:1) In addition, with 3.4 million women having died of HIV and Aids in 2012 (UNAIDS-AIDS by Numbers, 2013:1), it is clear that HIV and Aids has caused immense suffering to children and families with the most obvious effect of illness and death. The progression of HIV to Aids in the absence of Antiretroviral therapy (ART) is indefinite as a person may develop Aids within months or weeks after diagnosis and may require medical attention at local clinics or hospitals due to opportunistic infections, thereby putting great pressure on both the health system and the health care worker (Abdool Karim & Abdool Karim, 2010:71; Stine, 2012:157).

Evidence that there is no cure for HIV and Aids and the unpredictability of the progress of the disease result in a great deal of physical, emotional, economical and psychological suffering. The health sector rendering services to both infected and affected children and adults has to

carry an additional burden on the already strained care system. Abdool Karim and Abdool Karim (2010:363) reveal that the increasing incidence of both Tuberculosis (TB) and HIV have also had a huge impact on South African health care services and hospitals. The enormity of the HIV epidemic and TB in South Africa has obscured the other chronic illnesses facing the health system (Irin South Africa, 2013:1). This results in a high demand for personnel in order to care for infected or affected households.

Because HIV and Aids is not a notifiable disease, both patients and health care workers are equally at risk of contracting HIV from each other. In 2002 a study done in South Africa on the effects of HIV and Aids on conducting professional duties amongst provincial hospitals showed that 95 percent of professionals indicated that HIV and Aids had a severe physical and mental impact on them, which was caused by operational matters pertaining to their work (Daniel, Naidoo, Pillay & Southall, 2010; Shisana et al., 2004:65). One impact is stress or burn-out experienced by staff being overworked due to absenteeism. Another impact relates to the inability to properly engage in patient care as the professionals normally are not aware of the patient status and therefore fear the possibility of infection and experience frustration and depression. Another study conducted in South Africa also indicates that some nursing staff suffer severe stress after a needle prick, even when results are negative (Mothiba, Lebese & Maputle, 2012:186).

The latter may result in poor performance by health care workers due to the effect of their work load. The work environment also impacted on staff behaviour as they are forced to use gloves that often do not fit (Daniel et al., 2010). Science Daily (2014:1-4) reports that South Africa's health care workers face greater health challenges through seeing more patients with TB, HIV and Hepatitis B. UNAIDS (2013:60) has revealed that 94 percent of deceased patients were HIV infected and 50 percent were TB positive in 2010.

Effects of HIV and Aids do not have an impact on the hospital or health sector only. From the above it is clear that health care workers who provide the medical care and support are also affected as they themselves may be infected because they are as vulnerable to the same route of infection as all other individuals (Abdool Karim & Abdool Karim, 2005:347). They may simultaneously also put the patients at risk of contracting TB from them. There is also Evidence from studies conducted at Tygerberg Hospital in 2008 also confirm that 91 percent of medical doctors had been exposed to needle prick injuries and 55 percent had been exposed to HIV, and

also that 130 TB cases had been identified amongst health care workers and auxiliary workers (Eshun-Wilson, Zeier, Barnes & Taljaard, 2008:9).

From the above it is clear that the health sector provides a doubly vulnerable public service as both health care workers and patients face morbidity or mortality due to HIV and Aids, which, in turn, affects the effective functioning and economy of the country.

The consequences of HIV for health care is also revealed by the HIV disease progression in children which is much more radical due to malnutrition and other opportunistic infections like diarrhoea, pneumonia, TB and developmental delays. These symptoms require frequent admission to hospitals or clinic attendance (Gow & Desmond, 2002:68). A five-year study of hospitalised children in a hospital in the Western Cape reported that most of the HIV-affected children admitted present with severe malnutrition and poor nutritional status, which result in fast progression of disease and subsequent early death (Cotton, Schaaf, Willemsen, Veenendal & Van Rensburg, 1998:49). A study undertaken in the Cape Metropole from 1994 to 1999 likewise revealed that malnutrition among infants and young children poses a severe health challenge which leads to underweight and delayed development amongst children in South Africa (Andresen, Wandel, Eide, Herselman & Iversen, 2009:90). Meanwhile, both infected and affected individuals who are malnourished need medical, nutritional and social support to survive (Spencer, Herman, Naiker & Gohre, 2007:22. It is therefore evident that children, women and households being infected or affected are hard-hit by the effects of HIV/Aids. South African women, like all women in the world, are generally responsible for the provision of physical and emotional care of their entire families (Zungu-Dirwayi et al., 2004:63). These consequences have a devastating impact on affected households, more so because progress of the illness and/or death normally results in losing one's job.

3.4.7 Economic consequences

In South Africa the HIV epidemic mostly affects the working age group of the population. Statistics South Africa indicates that the greater majority of HIV infection or death of both men and women occurs between the ages of 25 to 35 years (UNAIDS, 2013:1). In addition, the prevalence of HIV is higher amongst the disadvantaged who are unemployed, the most impoverished persons with low skills and low income (Daniel et al., 2010:307). Although the abovementioned age group is the most economic productive age group, being HIV-infected or affected they may either die at an early age, possibly leaving those in the affected household to

quit their jobs to care for them because they are sick (Thurlow, Gow & George 2009:4). It is recognised that unemployment or family death results in major financial challenges which lead to families resorting to debt when their savings are depleted (Abdool Karim & Abdool Karim, 2010:417). Food consumption may drop simultaneously and may affect children and the household through becoming malnourished, which may lead to the rapid progression of HIV to Aids (Rohleder et al., 2009:207).

In addition, for children, the loss of income and unemployment of their carers may lead to poor cognitive functioning and result in unsatisfactory progress at school. Furthermore, poor economic status may result in these families not being able to access health facilities and may result in early mortality and morbidity. Sadly, the economic hardship faced by these households may lead to individual behaviour changes. Abdool Karim and Abdool Karim (2010:418) maintain that poverty may drive many women into sexual associations in order to provide for themselves and their children.

Therefore, major challenges face both affected children and the entire household as soon as the parent or parents becomes ill or die (Loewenson, Hadingham & Whiteside, 2009:1033). It is clear that more poor people are infected because they are poorer, and that Aids increases poverty. In summing up: the HIV and Aids pandemic has severe effects for many households as becoming ill results in skills lost and family disorganisation that leads to poverty, which affects the entire family and the economic situation in the country (Verster, 2012:12).

3.4.8 Welfare consequences

Having discussed the profound consequences that HIV and Aids have on affected households in various ways, it becomes evident that intervention from various stake holders is required to ensure the welfare of these families.

HIV and Aids care makes demands on their families and communities because their needs cannot be met by an institution such as a hospital alone. Many households are affected by HIV and Aids in South Africa and are in need of care and support services outside the family system. Such care and support need to benefit both the affected child and the family. Thus Anderson, Ryan, Taylor-Brown and White-Gray (1999:61) reveal that needs of HIV and Aids-infected children and families have been addressed since 1982 when welfare services began to be rendered to them as well as to those affected by HIV and Aids. Moreover, services had to both

expand and be adjusted as the pandemic grew. The community, civil society and the government all have a responsibility to ensure that all affected household needs are met.

It is clear that the consequences of HIV and Aids are complex and multifaceted because it does not impact the infected person only, but also impacts the lives of their households and the community at large. Therefore, it is crucial to understand the consequences of HIV and Aids for affected households. The effect that the environment has on these families, as well as on the social or structural systems that form part of these families should be recognised to understand how individuals relate to each other and to the entire society. The ecological perspective was therefore chosen as theoretical framework for this study. The motivation for this choice and the suitability of the ecological perspective to explain the need for social welfare services offered by NGOs to affected households are discussed next.

3.5 THEORETICAL PERSPECTIVE FOR THE STUDY

As discussed above, HIV/Aids have multiple consequences for affected households that range from the social, cultural, psychological and economic contexts. It is also evident that the consequences of HIV and Aids do not affect individuals only, but also families, groups and communities. In this regard it is worth nothing that Hepworth, Rooney, Dewberry Rooney and Strom-Gottfried (2013:6) maintain that the social work profession is one of the human services profession whose general purpose is to enhance the social functioning of individuals and groups through intervening by alleviating challenges such as poverty, discrimination, inadequate distribution of resources, interpersonal and personal difficulties.

The latter is a clear indication that social work is concerned with the holistically functioning of people, and therefore cannot distance itself from the need for social work to respond to the needs of HIV and Aids in affected households. The first cases of AIDS were first identified globally in 1981. Following this, the first cases of HIV and Aids in South Africa were reported in 1983 (Van Dyk, 2012:4). At that time the social work profession already had a long history of rendering health care services for people with chronic, acute and life-threatening illnesses (Aronstein & Thompson, 1998:xxi).

In addition, scientist and researchers became interested and is still interested in gathering information about the origins of HIV and Aids as a rare illness, how to prevent HIV transmission and how to be able to treat the virus. Moreover, researchers contribute to develop

policies and legislations to effectively deal with the epidemic from both a psychological and legal perspective (Van Dyk, 2012). It is worth noting that scholars such as Edmonds, Moore, Valdez and Tomlinson (2015:238) confirm that social workers played a crucial role in societies in response to HIV and Aids. They are aware of the availability of Antiretroviral treatment that is aiming to prolong the lives of those infected with HIV and Aids or health care services preventing mother-to-child transmission, as well as generally preventing infection of the most vulnerable women of child-bearing age and children. Thus the dominant role of social workers is to focus on adherence counselling and education in order to prevent HIV infection, as well as prevent mother-to-child transmission through administering prophylaxis (Strug, Grube & Beckerman, 2002:2). Authors such as Hepworth et al. (2013:6) explain that social workers offer preventative services to vulnerable people through counselling and education as well as providing relevant programmes and activities.

In providing information about HIV and Aids in order to prevent HIV transmission, social workers avail programmes for voluntary testing and counselling and the distribution of condoms. In addition, social workers offer intervention to families whose functioning has been impaired by physical and mental conditions like chronic illnesses. They render services to deal with the consequences of HIV and Aids for these families to regain their mental and physical ability in order to attain a desired level of social functioning (Hepworth et al., 2013:7). The latter can be attained through providing protection and care services to those families and children in need of care, meeting material needs, providing community home-based care, and support groups to deal with the physical and emotional needs of these households.

3.5.1 Ecological perspective

It is evident that HIV and Aids are influenced by individual and environmental factors. Therefore, in order to alleviate the consequences of HIV and Aids, social workers need to deal with environmental factors as well. The ecological perspective thus was the chosen theoretical framework for this study because it examines the interaction between the individual and his or her environment at various system levels (Nash et al., 2005:41-50). In addition, the ecological perspective allows an opportunity to gain understanding of the individual's relationship with groups, family, community and the entire environment. Moreover, the ecological perspective is helpful in conceptualising the social, psychosocial, historical, cultural, economic, political and physical, cultural and environmental factors that lead to increased vulnerability and exaggerated consequences of HIV and Aids for affected households. In addition, it allows social

work intervention at various systems levels such as individuals, family, groups and the larger community (Pardeck & Pardeck, 1988:144).

It is worth noting that Bronfenbrenner (2005 xiii) identifies different levels of the environment that can guide an understanding of the phenomenon and consequences of HIV and Aids for affected households from an ecological perspective which covers the micro system, mesosystem, exosystem and macro system (See Table 3.1 below).

Table 3.1: Ecological systems: levels of intervention

Micro system level	Individuals, couples and families
Mesosystem level	Support groups
Exosystem level	Workplace, health centre and social services
Macro system level	Economic, policies, legislation, culture, gender and values.

Source: Bronfenbrenner (2005)

The latter systems are also utilised in social work practice as social work practice methods. These interrelated systems are discussed below and also in Chapter 4 when discussing welfare services rendered to HIV and Aids-affected households.

3.5.2 The Micro system

The first level of the ecological system is the micro system. The microsystem is the primary focus of social work practice as it involves interaction with the individual, the couple and the family (Berg-Weger, 2010:220). Healy (2012:55) furthermore states that case work is one method of social work intervention with individuals and families. In HIV and Aids the microsystem refers to the infected and affected individual, as well as to significant others such as the carers, the individual's groups or organisations that, more likely, are going to endure the consequences of a person who is infected or dying due to Aids (Nash et al., 2005:59). Hepworth et al. (2006: 6) confirm that practice at micro level may be direct or clinical as services that are rendered face-to-face.by the social worker to the individual, family or group Therefore, in order to gain understanding of social work intervention at the micro system level, social workers need to intervene with individuals, couples and families, as discussed below.

3.5.2.1 Individuals

An HIV and Aids diagnosis first needs to be done for individuals. To obtain informed consent from the client, information about the test to be performed for the diagnosis to be made needs to be given by a professional person. Johnson and Yanca (2010:214) refer to this as the role of a teacher as the aim is to teach the individual about the facts of HIV and Aids transmission and about skills that can be utilised to prevent infection or further infection by condom use and the use of prophylaxis to prevent mother-to-child transmission. The social worker further teaches clients individual skills in order to enable them to deal or cope with the emotional consequences of the diagnoses. In addition, the social worker fulfils the role of a broker in referring the individual to relevant resources depending on the individual's needs. Furthermore, the social worker acts as a case manager as the social worker should take responsibility to ensure that the individual receives these services timeously, as some individuals may not be able to go to the referred resources due to ill health (Hepworth et al., 2006:28). In instances where these services are delayed, the social worker should intervene by liaising with the organisation for the client to obtain these services and in doing so play an advocacy role (Johnson & Yanca, 2010:214).

3.5.2.2 Couples

As indicated, the most common mode of HIV transmission is through sexual intercourse. Couples may attend the health center or antenatal clinic together. If a partner is not present the one who is present will be advised to bring the partner along in order to avoid the various consequences of HIV and Aids, such as domestic violence, disclosure and adherence issues. The social worker therefore takes on the roles of teacher, broker, case manager and advocacy in this regard (Johnson & Yanca, 2010:214; Hepworth et al., 2006). Both the individual and the couple are systems included in a family.

3.5.2.3 Families

The individual person may be the mother or the father and the couple may both be parents. The entire family therefore will endure the consequences of a positive HIV result if one or both parents fall ill or die due to HIV and Aids. The consequences of HIV and Aids for families are extreme because ill health may mean that a parent or both parents may lose their jobs, resulting in them losing income they need to support their children and other extended family members. Children who lose a parent or parents may suffer emotional distress such as trauma associated with grief. Consequently, they may not be able to attend school or complete schooling due to

other responsibilities or roles, or sometimes due to their own ill health (Gow & Desmond, 2002:97). Furthermore, they could become orphans, or have to live with one or more members infected with HIV.

Kirst-Ashman (2013:141) suggests that social workers in these situations should apply the role of an educator by providing information about how to deal or cope with the stressors and act as a broker and advocate.

3.5.3 The meso system

The second level of the ecological system is the meso system. The meso system refers to the infected person or the significant others in the infected person's life and the relationship between individuals and other micro systems (Nash et al., 2005:580). This, for example, will include self-help or therapy groups (Hepworth et al., 2006:14).

3.5.3.1 Support groups

Support groups consist of women with similar challenges, for example all being HIV positive and their children being at risk of mother-to-child transmission. The purpose of such a group can be to promote social change and achieve individual change (Healy, 2012:137). In addition, it can provide participants with an opportunity to learn from each other's experiences and insight. The social worker can, for instance, initiate a group with the intention of providing information about the associated risks of HIV and Aids and how to effectively prevent transmission. In doing so, the social worker can act as an educator and initiator (Johnson & Yanca, 2010:214). Furthermore, the social worker may facilitate support groups where those infected will have the opportunity to support each other to deal with challenges associated with HIV and the social worker can help them through guidance and assistance.

3.5.4 The Exosystem

The third level is the exosystem. The exosystem refers to an environment in which the individual is not directly involved, but impacts on the individual (Hosek, Harper, Lemos & Martinez, 2008:2). In an HIV and Aids context, the exosystem level includes other systems that are of importance in alleviating the consequences of HIV and Aids to affected households such as health care resources and social welfare services (Nash et al., 2005:56). As soon as an HIV diagnosis of an adult is made, children are more likely to be infected with HIV and affected by HIV and Aids. This, in turn, may result in the need for medical attention, and result in material

problems, poverty, food insecurity and a need for welfare services (Rohleder et al., 2009:70). These needs are discussed in the section below.

3.5.4.1 Health care

Having discussed the modes of HIV transmission in children it becomes evident that these children require medical intervention as soon as their mothers become pregnant, during the birth process and immediately after birth. At this level of intervention, social workers should work closely with the medical team in order to ensure that the child and mother are linked to outside health centres, are referred to or linked with relevant community-based services in order to receive the necessary health services (Edmonds et al., 2015:238). Furthermore, social workers should perform the roles of broker and educator and act as an advocate (Johnson & Yanca, 2010:214). HIV and Aids is not only a health-associated disease as its consequences result in psychosocial issues. Therefore, in order to effectively deal with its consequences, the welfare of HIV and Aids-affected households also need attention.

3.5.4.2 Welfare

HIV diagnosis in adults' results in HIV-infected children as well as children affected by HIV. These results can disrupt children's lives due to ill health or the death of their parents and put their health, education, welfare and security at risk. Hence Deacon and Stephrey (2007:1) summarise the consequences of HIV and Aids as physical, emotional, psychological as well as economical. In this regard Edmonds et al. (2015:238) confirm that social workers have played a crucial role in dealing with the consequences of HIV and Aids since the discovery of HIV. They furthermore maintain that these social welfare services should be delivered by social workers employed by governmental and non-governmental organisations. At this level the social worker's intervention commences immediately after a positive HIV result is made. Kirst-Ashman (2013:392) suggests that the role of educator is then relevant because the social worker should provide the newly diagnosed person with information and facts about HIV and Aids, and also provide counselling to enable the person to deal with the immediate emotional experiences of the diagnosis. This requires the social worker to act as an enabler, broker and advocate.

3.5.5 The Macro system

The fourth level is the macro system. The macro system is the largest and global intervention that focuses on economic, social, cultural and political values that impact the entire society in order to have a just society (Hosek et al., 2008:3). In social work practice macro system intervention intends to promote changes in policies and legislation that affect individuals, groups, communities, organisations and countries (Berg-Weger, 2010:268). In the HIV and Aids context in South Africa, Nash et al. (2005:55) refer to the macro system as societal structures that deal with gender issues, discrimination, beliefs, culture, political issues, tradition, and economic and religious matters that, in most instances, hinder prevention and an adequate response to the HIV and Aids epidemic. In this instance, social the worker performs the roles of teacher, enabler, and broker, and acts as an advocate.

3.6 CONCLUSION

It is evident that HIV transmission in South Africa is more associated with people who live in poverty and experience inequality. Sadly, the most vulnerable people exposed to HIV transmission are children and women. Its consequences cause major psychosocial stressors that require social work theories in order to guide social workers in gaining a better understanding of the consequences of HIV and Aids from an ecological perspective as well as from a systems theory perspective which mainly focus on the structural environmental factors in order to understand various barriers to HIV prevention and how each element influences another. In sum, it is evident that the consequences of HIV and Aids to affected households are both psychosocially and legally based. Therefore, intervention by means of legislation and policies is required to effectively deal with the consequences of HIV and Aids in affected households to reduce the number of new infections. The next chapter presents various international and national policies and legislation that specifically focus on the consequences of HIV and Aids.

CHAPTER 4:

POLICY AND LEGISLATION FOR SOCIAL WORK SERVICES RENDERED TO HOUSEHOLDS AFFECTED BY HIV AND AIDS

4.1 INTRODUCTION

Having discussed the extreme consequences faced by both infected and affected households, it becomes clear that HIV and Aids have both psychosocial and human rights consequences that require social work services guided by policies and legislation in order to address these consequences. The ways in which services for these households should be arranged cannot be explained without a sound understanding of policies and legislation related to the phenomenon. Hence this chapter aims to meet objective two of the research, as established in Chapter 1, which is to discuss how policies and legislation make provision for social work services rendered to households affected by HIV and Aids. This chapter is therefore focused on international, regional and national policies and legislation related to the care and protection of households affected by HIV and Aids.

4.2 GLOBAL POLICY RELATED TO CHILDREN AND WOMEN'S RIGHTS

The global HIV and Aids epidemic and the devastating consequences for human life and dignity and for how human rights of infected households are met contributed to the need for global policies to address the phenomenon. How the latter was achieved through an international response to prevent or manage the infection amongst children and prolonging the lives of their mothers is discussed in this section.

The consequences of HIV and Aids have caused major suffering and untold death globally amongst women and children for the past 30 years. Hence, the consequences of HIV and Aids have deprived affected children with regard to how some of their rights are met, as many of them have lost a parent or parents to HIV and Aids at a very young age or before reaching 18 years of age (Foster et al., 2005:70). Some international policies demonstrated that the consequences of HIV and Aids for children and households are related their human rights. Policies that address human rights and are related to this phenomenon are discussed next.

4.2.1 Declaration on the Rights of the Child (1924)

It is essential to note that the Declaration on the Rights of the Child (1924) entitled children the right to be solely protected and their well-being to be recognised even before the outbreak of the HIV and Aids epidemic (Fottrell, 2000:2).

4.2.2 Universal Declaration of Human Rights (UDHR) (1948)

In the Universal Declaration of Human Rights (UDHR) (1948), article 25 specifically states that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services" (Brownlie, 1992:26). This is supported by article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR) (1966) which further emphasises the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Brownlie, 1992:118). In order to ascertain this enjoyment, The International Covenant on Civil and Political Rights (ICCPR) (1966) and the Universal Declaration of Human Rights (1948) article 12 was put in place the same year to ensure the right to privacy and any form of discrimination (Brownlie, 1992:131). It is evident that it is mandatory that all human beings be entitled for their needs need to be fully and equally attained with respect and no form of discrimination in attaining their rights.

4.2.3 Convention on the Elimination of all Forms of Discrimination Against Women (1979)

Both the Convention on the Elimination of all Forms of Discrimination Against Women (1979) as well as the 1989 Convention on the Rights of the Child have been particularly influential in global attempts to minimise mother-to-child transmission of HIV and AIDS (Terry, 2007:140). The women's convention was adopted by the General Assembly of the United Nations on 18 December 1979. The aim was to give women the right to full development and freedom of human rights and to promote equality between men and women because women are bearers of human rights (Wolfgang, Esther & Gerd, 2002:34). Moreover, Article 12 of the Convention on the Elimination of all Forms of Discrimination Against Women states that equality also includes access to health care services and that all parties "shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure on a basis of equality of men and women, access to health care services, including those related to family planning".

Article 12 further comments on the right to health, stating that "state parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

It can be safely inferred from the above articles that there is a close knit between the rights of women and children and that women's health and social and economic status are directly related to the child's prospects for survival and development even before a child is born (Piwoz & Bedley, 2005:935). The Convention on the Elimination of all Forms of Discrimination Against Women (1997) is one of the international policies that created international standards related to the right to life, development, freedom and survival and the fundamental goal is to apply this policy to all women and children in order to assure equality.

Based on the above discussion it becomes evident that the rights of children and women are tightly knit together. Thus, advocating for women's rights is essential to advancing their situation, as well as promoting children's rights and improvement in their ability to survive and thrive.

4.2.4 United Nations Convention on the Rights of the Child (UNCRC) (1989)

It is worth noting that The United Nations Convention on the Rights of the Child (UNCRC) (1989) is the first approved human rights document focused specifically on children. However, children have many of the rights of adults in addition to particular rights for children that are relevant to HIV and AIDS (Twum-Danso Imoh & Ansell, 2014:1). Although the HIV and AIDS epidemic was not a motivating factor in creating the UNCRC (1989), this convention applies to every area of children's life and focuses on the four principles of non-discrimination, namely (1) best interest of the child, (2) the inherent right to life, (3) survival and development, and (4) participation of the child in decision making (Twum-Danso Imoh & Ansel, 2014:1). These rights are discussed below:

4.2.4.1 Best interest of the child

Article 3 focuses on the best interest of the child as of paramount importance in all matters concerning the child in developing and implementing relevant HIV and Aids prevention and care.

4.2.4.2 The inherent right to life

Article 6 of the UNCRC 1989 provides that state parties recognise "the inherent right to life" and agree to ensure to the maximum extent possible the survival and development of the child and "underscores the role of health condition and health actions in survival" (UNICEF, 1995:70). The latter is related to the discussion below on the child's right to health and health services.

4.2.4.3 Survival and development

Article 24 of the UNCRC (1989) focuses on the child's rights to health and health services, while section 2(a) clearly indicates that both infant and child mortality need to be diminished. The entire article 24 encompasses the four broad principles stated above, however. Section 1(one) of Article 25 focuses on the right of the child to be cared for and protected. The right of the child to be on treatment and be monitored as well as taking into consideration all the circumstances relevant to the above to avoid any harm (Brownlie, 1992:191-192). Hence the United Nations Committee on the Rights of the Child has identified four articles within the UNCRC that lay down general principles to which all nations should adhere.

These are: Article 2 of the UNCRC that stipulates that all children should be treated equally and experience non-discrimination. Furthermore, Article 18 of the Convention on the Rights of the Child (1989) provides basic human rights to all children to promote a parent or legal guardian to primarily take full responsibility for the upbringing and development of the child with the most prominent role in the child's health (Brownlie, 1992:188). Section 18(2) further notes that, in order for parents to effectively perform these responsibilities, they need proper guidance in terms of raising these children in order for them to develop fully. The latter can be attained through educating the child in order for the child to develop to the fullest potential with regard to personal, mental and physical development.

4.2.4.4 Participation of the child in decision making

Article 12 states that children's views need to be respected at all times (Foster et al., 2005:142-143). Article 3 of the Convention on the Rights of the Child (1989) states that, in each and every decision affecting the child, the various possible solutions must be considered and due weight given to the child's best interest (Rosenblatt, 2000:222). Article 25 further reads "state parties recognize the right of the child who have been placed by the competent authorities for the

purpose of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement (Rosenblatt, 2000:228-229).

Article 37 in the Convention on the Rights of the Child (1989) emphasises that depriving the child from the above may lead to the right to access legal or any appropriate services to ensure that the child's rights are not violated (Brownlie, 1992:195).

4.2.5 Millennium Development Goals (2000)

Another significant policy is the Millennium Development Goals. The 2000 Millennium Development goals were set by world leaders committing themselves to meet these goals in 2015. The goals range from combating extreme poverty, the spread of HIV and Aids, discrimination against women, and improving maternal health (United Nations, 2002:3). These goals were set to be implemented and to monitor progress in human and child development with specific focus on child development as the major goal.

4.2.6 World Summit on Sustainable Development (2002)

Various international commitments linked to the attainment of enhancing child development were undertaken for child survival. The World Summit on Sustainable Development Goals in 2002 requires each country to reduce the number of infants infected by HIV. The major goals that were set at this summit are related to the goals targeting the protection and development of children.

In addition, other goals that were set supported the above and also include the promotion of women's health and provision of education, nutrition, water and sanitation and addressing children's rights in especially difficult circumstances and many more (United Nations, 2002:41-107).

After the World Summit in 2002, child health experts gathered in Bellagio (Italy) to exchange ideas and views on issues related to child death in order to evaluate strategies for reducing child mortality. It was at this meeting of the Bellagio Study Group on Child Survival in 2003 that a commitment to improve the survival of millions of children who face death from preventable diseases such as diarrhoea, pneumonia, measles, malaria, HIV and Aids, and causes of undernourishment was initiated (Jones, Steketee, Black, Bhutta, Morris & the Bellagio Child Survival Study Group, 2003).

As discussed in Chapter 1, HIV and Aids mostly affects African countries with unimaginable numbers of death among adults in their productive years. The majority of people that are infected also are women and children who live in extreme poverty, who are vulnerable to social and sexual exploitation, and poor nutrition, and who lack protection (Foster et al., 2005:93). Thus the lack of protection of human rights can become a matter of life and death. However, safeguarding those rights can enable people to avoid infection or, if already infected, enable them to cope successfully with the consequences of HIV and Aids. The following section presents a discussion of policies in Africa that are relevant to households affected by HIV and Aids.

4.3 REGIONAL POLICIES ON HUMAN RIGHTS

Sub-Saharan countries are characterised by different cultures or practices and ethics, poverty, and the most serious prevalence of the HIV and Aids epidemic in the world. In addition, women and children are most affected by both the consequences of poverty and HIV and Aids, which have an enormous impact on health care, schools and education, labour and productivity and economic development (Doyal & Doyal, 2013:27).

The Organization of Africa Unity (OAU) felt that international human rights policies and treaties were not enough and that Africa needed its own unique treaties that would work hand in hand with the existing international conventions in order to achieve a flexible approach to the Sub–Saharan challenge. Thus a need for the development of regional policies was of paramount importance. The relevant policies are discussed below.

4.3.1 African Charter on the Rights and Welfare of the Child (1990)

The African Charter on the Rights and Welfare of the Child (ACRWC or Children's Charter) was adopted in 1990 by the Organization of African Unity (OAU), which became the African Union in 2001. This document was endorsed by South Africa in 1999. Similar to the UNCRC (1989) and the ACRWC (1990) they are comprehensive policies that set out rights and define universal principles and norms concerning the status of children.

As a regional human rights policy the ACRWC deals with issues such as economic, social, political, cultural and historic experiences of African children that cannot be dealt with on a global scale (Kaime, 2009:3). The ACRWC sets out the rights of the child as well as the responsibilities of the parent, parents or carer. African children are from different cultural,

different economic backgrounds and different social circumstances and some children are living in child-headed households or living with HIV and AIDS. Consequently, this charter was designed to be flexible enough to adjust to these circumstances in order to adequately meet the rights and welfare, specifically of the ACRWC (Kaime, 2009:93). The Rights of the Children contained in the UNCRC (1989) have also found their way into the African Children's Charter (Kaime, 2009:93). Like the UNCRC (1989), the ACRWC indicates that every human being below the age of 18 years is a child and every child should be afforded basic human rights without discrimination. These human rights include the right to life, the right to freedom of expression, association, thought, conscience and religion (Foster et al., 2005:135). Thus the parents and carers have an obligation to provide guidance and direction to children in the exercise of these rights.

4.3.1.1 Basic principles

It should be noted that the ACRWC contains rights that are specifically focused on the African child in a different social space, namely living with HIV and Aids and living in child-headed households and is aimed at protecting their rights. Thus this Charter contains specific rights for children such as the right to rest and leisure, to engage in play and recreational activities and the right to parental care and protection. However, with regard to this study, the most essential similarity with the UNCRC (1989) is the Charter's commitment to the best interest of the child, promoting the child's survival and development, anti-discrimination and the child's participation in decision making. Therefore, in order to meet the four basic principles, it needs to be implemented with specific focus on the best interest of the child so as to meet their welfare needs (Kaime, 2009:109). Hence Article 4 of the UNCRC cites "In all actions concerning the child undertaken by any person or authority the best interest of the child shall be the primary consideration." The four basic principles are discussed below.

4.3.1.1.1 Best interest of the child

The first principle is to act in the best interest of the child. The ACRWC (1990) recognises children as people in need of protection and special care who therefore have a right for that need to be acted on in their best interest. According to Thornberry (2002:247), both the UNCRC and ACRWC are committed to the welfare of African families, while the ACRWC expressly expects state parties as well as parents to be committed to serve the best interest of the child as the primary consideration (Kaime, 2009:110). Furthermore, the concept of the best interest of

the child can be applied to the different development stages of the child, the child's living conditions, cultural norms and expectations. Hence the principle of the best interest of the child can be applied to HIV prevention, care and research programmes (Foster et al., 2005:142).

In the African context it is dictated that any person could be the community or family, or a court which should be acting in the best interest of the child. This entails that the ACRWC dictates that the best interest of the child should be respected by all human beings (Kaime, 2009:112-113).

The ACRWC plays a vital role in protecting the rights of children and more specifically the rights of the HIV and Aids-infected and affected children in an African context. Although the rights are similar to those in UNCRC and can be utilised in response to the HIV and Aids epidemic, it is specifically designed to focus on the unique circumstances of the African child. The ARWC puts children's rights in legal and cultural perspective in order that political and scientific agencies consider the best interest of the child as paramount in terms of their rights to treatment, care and support. Ige and Quinlam (2012:3) indicate that, prior to the ACRWC, the African view on how to deal with the consequences of HIV and Aids in an African context or view were totally ignored or silenced. Hence the ACRWC made a collective recognition of the rights and welfare of African children and established a policy framework for their protection.

The ACRWC and the UNCRC are international and regional human rights treaties that cover the whole spectrum of rights, however the UNCRC does not specifically mention the African HIV and Aids child, but the rights can be directly linked to these children (Foster et al., 2005:140).

Article 9 of the ACRWC focuses on the best interest of the child, the child's freedom of thought, conscience and religion which relates to Article 19, which gives the child the right to parental care and protection, and Article 20, which focuses on parental responsibility either by the parent or the carer (Kaime, 2009:109). However, the ACRWC identifies areas where the best interest of the child is not a primary consideration, for example the permanent or temporary deprivation of children of the family environment and the separation of the children from adults. In such situations they are deprived of making their own decisions (Kaime, 2009:110). Thus it is recommended that the best interest of the child be of importance when implementing HIV and Aids prevention, care, support and research programmes (Foster et al., 2005:93). What is of

relevance to this study, is that articles from the ACRWC can add value when social workers are facilitating intervention relating to HIV and Aids-affected households, for instance Article 3, 4(2), 6, 7 and 12.

4.3.1.1.2 The child's right to life, survival and development

The second principle focuses on the child's right to life, survival and development. Articles 6 and 7 state that every child has a right to life and mandate the government the obligation to protect this right. This right entails that children should benefit from economic and social policies that will allow them to survive in adulthood. Thus Article 7 requires that all children should be registered at birth in order to qualify as citizens. Furthermore, in order to ensure the above children's rights are met, Article 14 and Article 21(1) oblige the government to reduce infant and child mortality by ensuring that all women and children have access to medical care and are protected in all inappropriate measures that may affect the health or life, welfare, moral growth and development of the child (Kaime, 2009:195-196).

4.3.1.1.3 The child's right to be protected from any kind of discrimination

The third principle concerns the child's right to be protected from any kind of discrimination. Articles 3 and 4(2) require that every child be protected from any kind of discrimination, irrespective of his or her parent's or legal guardian's background or social circumstances that may impact on the child's current condition. Article 4(2) entrenched the most important responsibility of the parent or legal guardian, namely to ensure that these children are not discriminated against, thus assisting them in making decisions (Kaime, 2009: 98-110).

4.3.1.1.4 The child's right to express his or her views and opinions

The fourth principle concerns the child's right to express his or her views. Article 12 guarantees the right for children to participate through allowing the child to express his or her opinion and views in all matters that directly affect him or her, and to be heard, considered and given due weight. According to Kaime (1999:21), Article 12 implies that the participation of children has become an important feature in the arena of children's rights as it gives them the possibility of self-exploration in matters affecting them directly.

With regard to Articles 3, 4, 6, 7 and 12 it is evident that the ACRWC establishes an obligation to recognise the rights and freedom of children and to undertake the necessary steps in implementing it as prescribed by the UNCRC (1989).

4.3.1.2 Implementation of principles

To ensure effective implementation, attention must be given to parental responsibilities in relation to the child. These responsibilities should be clearly specified and defined in an intervention plan to ensure that parents understand their duties and roles in terms of meeting the best interest of the child, and in protecting the child from discrimination. However, if parents or guardians are unable to adhere to these responsibilities, they are entitled to the fundamental protection and care provided by government, more especially in terms of the life, survival and development of the child where only government's intervention is fundamental. Again these treaties stipulate the responsibility of both the government and families in the life and health of both the child and the parent in order to save and prolong lives and eliminate mother-to-child transmission through treatment care and support.

Like the African Charter, the Children's Charter recognises the family as the basic unit of society and requires state parties to protect and support the establishment and development of families (Kaime, 1999:111). However, the duty for family cohesion does not lie on the state only, but on family members as well. Thus, as a number of family members are kept together in the African culture in terms of immediate and extended, as well as clan-related relationships, all should take part in taking responsibility for protecting and taking care of families (Kaime, 1999:116). Due to the sexual mode of transmission, HIV generally causes the death of both parents over a short period. Thus a wider traditional family system to care is developed either from maternal or paternal kin, like uncles, aunts, grandparents or an older sibling in the household (Foster et al., 2005:243). Parents have traditionally taken responsibility for the upbringing and development of their children as the children were their only way of investing in the future. As a result, the approach of the Children's Charter focuses not only on the welfare or interest of an individual member or child, but rather on the group or extended family.

The UNCRC (1989) and the ACRWC (1990) are the two fundamental human rights treaties that are complementary and focus on children's rights. For the purpose of this study, the similar principles that these human rights treaties present with specific focus on how detailed each principle is presented. The differences are presented in Table 4.1 below.

Table 4.1: UNCRC (1989) and ACRWC (1990) Differences

Table 4.1.1 Principle 1: Non-discrimination

Principles	UNCRC 1989	UNCRC 1990	Differences
1. Non-discrimination	Article 2(1) requires that all rights as stipulated in the UNCRC (1989) are to be enjoyed by all children without any discrimination irrespective of the child's or his or her parents' or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. Article 2(2) further puts emphasis on state parties to ensure that all children are protected against discrimination of all kinds on the basis of the status, expressed views or beliefs of the child's parents, legal guardian or family members.	Article 3 requires that all rights set in the ACRWC (1990) be accorded to all children without any discrimination irrespective of the child's or his or her parents' or legal guardian's race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.	Article 2 of the UNCRC (1989) includes non-discrimination on grounds of disability, which is not in the ACRWC (1990); however, Article 13 of the ACRWC (1990) protects the right to protection for children with disability.

Table 4.1.2 Principle 2: Best interest of the child

Principles	UNCRC 1989	UNCRC 1990	Differences
2. Best interest of the child	Article 3(1) requires that the best interest of the child is of primary consideration in all actions concerning the child, whether undertaken by public or private social welfare institutions, court of law, administrative authorities or legislative bodies. Article 3(2) requires that state parties ensure that the parents take legal responsibility in	Article 4(1) "In all actions concerning the child undertaken by any person or authority the best interest of the child shall be the primary consideration." Article 4(2) requires that "in all judicial or administration proceedings affecting a child who is capable of communicating his or her own views an opportunity for his or her views to be heard	UNCRC (1989) solely focuses on the best interest of the child where legal processes are involved, and excludes the family or any other person in any matter concerning the child as well as the child's views. The ARCWC (1990) Article 4(1) recommends the child's views to be considered in accordance with considering any other

Principles	UNCRC 1989	UNCRC 1990	Differences
	order to protect and care for the children.	directly or through an impartial representative should be taken into consideration by the relevant authority in accordance with the appropriate law".	persons or the family in matters concerning children in order to meet the best interest of the child. Article 4(2) has more relevance to family or non-family traditional placement that involves other persons, for example in translation.

Table 4.1.3 Principle 3: Right to life, survival and development

Principles	UNCRC 1989	UNCRC 1990	Differences
3. Right to life, survival and development	Article 6(1) requires that state parties recognise that every child has the inherent right to life, Article 6(2) further requires that state parties ensure, to the maximum extent possible' the survival and development of the child. Article 24(1) obligates the state parties to recognise the right of the child to the enjoyment of the highest attainable standard of health and state parties to ensure that no child is deprived of his or her right of access to health care services. Article 24(2a) and (2d) requires state parties to address and take appropriate measures to "diminish infant and child mortality and to ensure appropriate pre-natal and post-natal health care for mothers.	Article 5(1) reads "every child has an inherent right to life" Article 5(2) further reads that state parties should ensure that the survival, protection and development of the child be met. Article 14 obliges the state parties to take the following measures (a) to reduce infant and child mortality (d) to combat diseases and malnutrition within the framework of primary health care (e) ensure appropriate health care for expectant and nursing mothers (f) develop preventative health care regarding family life education and provision of service (g) integrating basic health service programmes in national development plans (h) to ensure that all members of society are given adequate knowledge on child health, nutrition, advantages of breast feeding and finally (i) to	UNCRC (1989) focuses on the child's right to life and that state parties have a responsibility that these health rights are met in order to combat infant and child mortality through proper pre- and post-natal care. ACRWC (1990) presents detailed measures as to how mother and child mortality can be eliminated through preventative education and involving non-governmental and local communities in planning the management of health services for affected children and households.

Principles	UNCRC 1989	UNCRC 1990	Differences
		involve Non-governmental organisations in the planning and management of a basic service programme for children.	

Table 4.1.4 Principle 4: The child's right to express his or her views

Principles	UNCRC 1989	ACRWC 1990	Differences
4. The child's right to express his or her views	Article 12 guarantees a child who is capable of forming his or her own views the right to participate by allowing the child the opportunity to express his or her opinion and views in all matters that directly affect him or her and to have it heard, considered and given due weight.	Article 7 guarantees every child who is capable of communicating his or her views the right to express his or her opinions freely in all matters. Article 9 mandates the parents or legal guardian the responsibility of guidance and direction in order to assist the child in making sound decisions and so to meet the best interest of the child.	UNCRC 1989 Article 6 only focuses on the child's capability. However, the ARCWC 1990 involves the parent or guardian in instances where the child is not capable of making sound decisions due to being under developed or having health-related issues.

Source: Brownlie (1992) and Kaime (2009)

Given the above policies and differences it is of paramount importance that social work intervention strategies for alleviating the consequences of HIV and Aids in affected households need to consider the best interest of the child. This entails the provision of a set of economic, social, cultural, civil and political rights to protect children. These rights guaranteed by the Convention are afforded to all children with no exception (Doyal & Doyal, 2013:140).

The above-mentioned policies are in an optimal position to ensure that the rights of children under the UNCRC (1989), ACRWC (1990), the Millennium Development Goals (2000) and the World Summit Goals (2002) are upheld. Thus, there is a commitment to protect and ensure a child's survival rights and to be accountable for this commitment before the international community. South Africa has endorsed and adopted these policies.

4.4 NATIONAL POLICIES AND LEGISLATION

The following section comprises a discussion of the South African government's policies and legislation that are directed towards alleviating the consequences of HIV and Aids in affected households.

4.4.1 Constitution of the Republic of South Africa (1996)

The Constitution, which is the highest law in South Africa, is of utmost importance in this study as it obliges all other laws to comply with its provision. The Constitution of South Africa is often seen as a unique document in that it not only focuses on civil or political rights, but also on socio-economic and cultural rights in the chapter containing the Bill of Rights (Budlender et al., 2008:144). Most importantly, it is a Constitution which was endorsed more than 20 years ago after the end of the apartheid government in 1994. It further guarantees people living with HIV and Aids the same basic human rights and responsibilities as all other citizens of this country.

The South African government is signatory to the UNCRC (1989) and the ACRWC (1990) and this reflects South Africa's commitment to culture orientated rights. Thus, it places section 27 and 28 of the Constitution, which exclusively deals with children's rights and which is part of the Bill of Rights in the Constitution, as primarily important for this study.

Because affected children are indirectly affected by the epidemic, because their parents are infected or have died of HIV, these children are also presumed to be HIV positive. They therefore are isolated from other children, teased by their peers and experience stigma and discrimination at home, at school and in their leisure environments (Save the Children, 2001:16).

These children have normally experienced tremendous losses, for instance loss of their parents and other support structures. They also experience feelings of shame, fear, anxiety and many other feelings and finally have to cope in silence as they fear becoming known as affected children (Citron et al., 2005:196). In addition to the trauma and grief experienced by children after the death of a parent or parents due to HIV and Aids, these children are facing a double burden in being exposed to stigma and discrimination (Wang, Xiaoming, Bernett. Zhao & Stanton, 2012:1437). The stigma attached to the disease also results in reluctance to disclosure (Shisana et al., 2004:65).

In cases where the parents are still alive the children are exposed to or at risk of limited parent-child interaction as the parent might fear infecting the child, which is also a form of discrimination and isolation depriving the child from the emotional support of his or her parent (The Framework, 2004:1). The loss of a parent or parents means that these children have lost attachment and the protection from their parents as well as being deprived from education.

Thus the Constitution focuses on children's rights in relation to parental health care during and after pregnancy in order to prevent mother-to-child transmission of HIV and Aids as well as ensuring their wellbeing.

4.4.1.1 The Bill of Rights

The Bill of Rights protects families and infected and affected children.

(a) Section 27(1a) of the Bill of Rights guarantees everyone the right to health care services including pre- and post-natal health care services.

(b) Section 28(1a) guarantees the right to citizenship, which means every child has the right to a name and nationality at birth. Therefore, support of affected households' social security and social relief, normally in the form of food and finance, is of paramount importance for these households' survival (Gow & Desmond, 2002:10).

(c) Section 28(1c) guarantees the right to housing, food, medical care services, social security and welfare for all children. In the context of HIV and Aids the main aim of the Millennium Development Goals (2000) is child survival through early access to treatment during pregnancy so as to reduce infant, child and maternal death (Ross & Deverell, 2004:216). Maternal nutrition plays a vital role in reducing mother-to-child transmission, as well as prolonging both the mother and the child's health (Kibel & Wagstaff, 2005:70). Furthermore, affected households are more likely to be exposed to malnutrition and poor access to health services due to poor supervision and care, hence nutrition is linked to treatment and health for survival and development (Foster et al., 2005: 11). The death or ill health of a parent results in children's inability enjoy the fulfilment of their basic needs as it leads to vulnerability, lack of proper care and supervision, inability to access health care, education and many more, which results in their welfare needs not being met (Foster et al., 2005:94). For infants to have access to the above services and many more, they need to be citizens and therefore need to be registered at birth (Grannis, 2011:91).

(d) Section 28(fii) warns against putting the child's wellbeing, early physical and neonatal, spiritual, moral or social development at risk. Thus the South African Constitution includes a Bill of Rights which lists basic human rights to all South African citizens including people living with HIV and Aids. The above-mentioned rights are embodied in section 28(2), which states that the best interest of the child is of paramount importance in every matter concerning the child.

From the above two sub-sections of the South African Constitution (1996), it is evident that children are bearers of rights that include the right to nutrition, shelter, health care services and social services. Thus, for these rights to be fully implemented to affected households, the White Paper for Social Development (1997) assures developmental social welfare services in order to alleviate poverty.

4.4.2 The White Paper for Social Welfare (1997)

Having discussed the consequences of HIV and Aids for affected households it becomes evident that these consequences are more evident in Sub-Saharan countries that already face poverty and inequality. The White Paper for Social Welfare (1997) is a response developed to address the socioeconomic consequences of poverty and inequality experienced by households affected by HIV and Aids. Therefore, in order to meet the welfare of HIV and Aids-affected households, various social services facilities, programmes and social security interventions are needed to promote social justice and development in meeting the economic needs of these households (Lombard, 2008:154).

In order to meet the welfare of these affected households, the capacity of these families to care for their children needs to be strengthened in order to enable these children to cope with the consequences. Chapters 7 and 8 of the White Paper for Social Welfare (1997) has relevance to this study. Chapter 7 focuses on social security or social assistance in the form of cash or transfers in kind in order to assist families who cannot cope with the consequences of HIV and Aids in affected households, as well as alleviate poverty. Chapter 8 focuses on family integration because the consequences of HIV and Aids include family disorganisation, discrimination, family violence, role changes, child-headed households, concurrent partners for financial benefits in order to maintain their families. Therefore, programmes are required to accommodate the needs of the children through appropriate alternative care within their communities or environment.

4.4.3 The 1997 reviewed White Paper for Social Welfare (2016)

The White Paper for Social Welfare (1997) was reviewed in 2013 and now focuses on involving families and communities by availing projects that will benefit affected HIV and Aids households, such as to involve them in food gardens or obtaining food parcels, school uniforms, food, clothing, blankets and stationery. In addition various programmes, for instance Home and Community-Based care (HCBC) programmes, should be directed to children who are orphaned and therefore vulnerable to HIV and Aids as well as other vulnerable children to promote the welfare of HIV and Aids-affected households (Comprehensive report on the review of The White Paper for Social Welfare, 1997; 2016:140-143).

The South African Constitution (1996), The White Paper for Social Welfare (1997) and the revised White Paper for Social Welfare (2016) clearly indicate that children are bearers of rights that include the right to nutrition, shelter, health care services, social welfare services and social work service intervention. Hence children are dependent on their parents or carers to take responsibility for seeing that these rights are met. The White Paper on Families (2012) is discussed below to present a brief explanation of how these families can be empowered in order to be able to care for their children and stay together as a united family.

4.4.4 The White Paper on Families in South Africa (2012)

Like the White Paper for Social Welfare (1997), the White Paper on Families in South Africa (2012:40) focuses on promoting healthy family life through protecting and preventing families from physical and mental harm, strengthening families through alleviating poverty, providing health care services through treatment for those infected and affected by HIV and Aids, education on reproductive health, family planning and nutrition. In order to promote the well-functioning of these families and empower them to be able to care, protect and support their families independently, the White Paper on Families in South Africa (2012:39-43) recommends implementation of the following strategies:

- Strategic Priority 1: **Promoting Healthy Family Life** through uplifting the importance of a family in terms of providing for the basic needs of families and their children, respecting each family member and not discriminating against them irrespective of their language, background, beliefs, or physical and mental condition.
- Strategic Priority 2: **Family Strengthening** through basic social assistance and security

in the form of grants and food, generating income, supporting families by providing them with caring skills or facilities to assist in promoting early child development and early health care intervention with specific focus on HIV and Aids-infected and affected parents and children.

- Strategic Priority 3: **Family Preservation** focusing on family safety through prevention and intervention to minimise child abuse, neglect, HIV and Aids, poverty, child and parent or parent mortality and thereby alleviate family disintegration such as is evident in child-headed households and to rather promote family reunification.

These priorities are reinforced in the Children's Act 38 of 2005 as well as in the Amended Children's Act 41 of 2007 in order to ensure that the children's rights as well as those of their families are protected.

4.4.5 The Children's Act 38 of 2005 and Amended Children's Act 41 of 2007

The Children's Act is a legal document aiming to protect and prevent children from physical, emotional and mental abuse as well as giving the parents, care givers and legal guardians the same responsibility to protect, support and care for the child with specific focus on the best interest of the child (Budlender et al., 2008:21). Like the Constitution (1996), both the Children's Act and the 2007 Amended Children's Act focus on the protection of the rights of the child, such as health status of the child, best interest of the child, consent for HIV testing, the child's right to confidentiality and the child's right to treatment care and support, parental responsibility and alternative care. These rights are now discussed:

4.4.5.1 Health status of children

This section presents a brief discussion on the health status of the child and consent with specific focus on the child's age and developmental stage, discrimination, confidentiality and parental, care giver and legal guardian responsibilities in order to maintain the best interest of the child. Section 6(a) of the Act refers to the child's right to be protected from any form of discrimination with regard to the child's health status or disability, including that of his or her family. In addition, section 6(2d) requires that all children and parents or families be protected from any kind of discrimination. In cases where the family is unable to protect these children it is expected from the government to protect such children (Foster et al., 2005:142). As affected children are directly affected by the epidemic because their parents are infected or have died of

HIV and Aids, these children are also presumed to be HIV-positive. They are isolated from other children, teased by their peers and experience stigma and discrimination at home, school and in their leisure environments (Save the Children, 2001:6).

4.4.5.2 Best interest of the child

Sections 9 and 10 of the Children's Act 38 of 2005 emphasise the best interest of the child at all times. Thus the child's views and participation in all matters concerning the child must be considered, depending on the child's maturity and stage of development.

4.4.5.3 Consent for HIV testing

The Children's Amended Act 41 of 2007 section 130-133 states that, in terms of testing, it must be in the best interest of the child, and that consent should be given by the child, parent or care giver when the child is under 12 years of age and not fully mature or able to understand the complications of the test. In addition, confidentiality should be maintained at all times to protect the child from any discrimination. Section 5 states the child's right to be informed of any action or decision taken in any matter that affects the child. However, the child's age, maturity and stage of development need to be considered or parental views and assistance aiming to protect the child is paramount. This right goes hand in hand with section 10 that recommends that, if such child is age appropriately matured and developmentally matured, that child has a right to participate and express his or her view and must be given consideration and, most importantly, in the best interest of the child, and parental care should be taken into consideration. In addition, sections 13(1a) and (b) guarantee every child the right to have information regarding his or her health in terms of prevention and treatment of illnesses, as well as his or her health status. In the HIV and Aids context, the HIV-affected child needs to be tested in order to receive the appropriate support, care and treatment services.

In addition to the above, in section 130-133 of the Act, section 130(2) refers to consent for HIV-testing and consent in instances where it is discovered that both parents or care givers are reluctant to give consent, which is not always in the best interest of the child, the children's court will ascertain the best interest of the child in order to give consent. When placement is arranged or the child is already placed, the child protection organisation and institution, may give consent for testing a child. Lastly, in terms of crisis, where a child is abandoned, and has no parents, or no welfare organisation or protection organisation is involved, the medical superintendent of that hospital needs to provide consent.

To perform HIV tests on a child, pre- and post-tests need to be performed by a trained person. A 12-year old or older child may be counselled when he or she is matured and fully understands the consequences of the HIV test. When a child is under 12 years or immature, with insufficient understanding of the consequences, the child's parent or carer may give consent, provided that such a person indicates good insight of the test. The same applies in post-test counselling.

4.4.5.4 The child's right to confidentiality

Any information regarding an individual's health is always confidential as it entails a person's privacy. It becomes worse with HIV and Aids as the disease itself is discriminative and yet has enormous consequences for children who comprise the most vulnerable population and have suffered enormous discrimination. Thus, section 13(d) emphasises the child's right to confidentiality regarding his or her health status, as well as the health status of the parent or carer except when maintaining such confidentiality is not in the best interest of the child. The child's insight during pre-test counselling will also be of help to ascertain the child's capability in dealing with disclosure or ability to fully understand the consequences of disclosure. Hence section 7(c), on the best interest of the child, states that the child needs to be protected from any physical or psychological harm caused, through subjecting the child to maltreatment and other harmful behaviour. Foster et al. (2005:156) confirm that the stigma and discrimination experienced by both infected and affected children and households result in psychological stress due to verbal and physical actions. Section 133 protects the status of HIV and Aids children, and therefore recommends that children should give consent to disclosure of their status. This section is similar to section 130 and 131 as the aim is to protect and prevent the child from any harm and honouring the best interest of the child.

In order to ascertain the child's capability or ability to understand the implications of an HIV test and disclosure, the child needs to be assessed various spheres, like the child's developmental or age level which refers to the amount of information the child will be capable of grasping and his or her ability to engage in an interview (Sherr, Croome, Castaneda, Bradshaw & Romero, 2014:75).

4.4.5.5 The child's right to treatment care and support

Section 13(1a) stipulates that every child has the right to access information on health promotion, prevention and treatment of ill health and disease. The latter is normally done in form of counselling by a counsellor or health worker in order to assure that the consent given

is informed consent. However, ascertaining the child's capability in terms of the child developmental stage might be complicated due to the progression of the disease, as well as the neurological complications that may lead to inadequate neuro-development in most children, as well as the health carer's and counsellor's own discretion that might not be appropriate (Save the Children, 2004:39).

Thus, for children to be protected and kept from any harm, their parents need to take responsibility to see to it that the children's needs are met. Hence the right to parental, family care, appropriate alternative care and social services, protection from abuse and neglect is solely enjoyed by children (Budlender et al., 2008:22).

4.4.5.6 Parental responsibility

Section 18(2) refers to parental responsibilities and rights that a person may have as the right to care for the child, to act as a guardian and to maintain contact with the child. These rights are of benefit to HIV and Aids-affected children who may not have a parent because of death or ill health. Thus section 32(1) makes provision for children who do not have a parent by giving the right to a person who can practice parental rights and accept those responsibilities temporarily or who can voluntarily care for the child. The following responsibilities can then be given to those carers which have the right to attend to the child's health, wellbeing and development, as well as to protect the child from discrimination, abuse, neglect, degradation physical and emotional abuse.

4.4.5.7 Alternative care

Richter et al. (2004:12) summarise the direct consequences of HIV and Aids for families and households as the emergence of child-headed households, family breakdown, increase in elderly care givers, separation of siblings, child abandonment, and children caring for older people. The latter results when children have no parents to care and take responsibility for them which places these children in the category of children in need of care. Section 150(1) and (2) refers to a child in need of care and protection as a child who has been abandoned or orphaned and has no visible means of support. Section 150(2) further refers to a child in need of care as a child in a child headed-household. Foster et al. (2005:241) confirmed that South Africa has a history of children who are living in poverty, and do not have the privilege of being represented by a biological mother or father. They are frequently exposed to different care givers, but the majority of these children live with other adult carers for most of their lives. Similarly, children

orphaned by HIV and Aids are normally cared for by other children and children may be abandoned by their mothers like their mothers were abandoned by their fathers when they disclosed their HIV statuses. A study of Sub Saharan countries reveals that 58 percent of children affected by HIV and abandoned are from health facilities (Wangai, Wangai, Beckenham & Beckenham, 2007:1).

It is evident that a core function of the South African Constitution (1996), The Children's Act 38 of 2005 and the Amended Children's Act 41 of 2007 is to see to it that all children are protected, cared for by their parents and prevented from any harm and to meet their basic needs through intervention which has the best interest of the child at heart. In addition to that, it also avails alternative legal intervention in parental absence in order to assure appropriate alternative care in the best interest of the child. However, it becomes clear that the needs of those left behind cannot always meet, due to ill health, death and poverty resulting from the epidemic. Therefore, as stipulated in the Constitution (1996), government needs to intervene when families cannot cope any more. In such a case, the families cannot cope with the demands of the epidemic and therefore require means to sustain their families.

For these households to function optimally, their welfare needs have to be met in order to sustain the carers' ability to care for them. Furthermore, disclosure is a challenge as it is essential for older children to be able to give consent to be tested in order to be treated and cared for when these children are growing and their minds develop. The progression of the illness and its effects on the brain result in neurological under development which is rarely reversible, resulting in their inability to further schooling and total dependence on their parents or carers for care. Hence, the World Summit (2002) and the Millennium Development Goals (2000) focus on protection of both women and children and preventing poverty. In South Africa, because of the severe consequences of HIV and AIDS for households and the prevalence of HIV and AIDS in many instances may mean that the household will dissolve because parents die and children are sent to immediate family or relatives and eventually to non-related family members or institutions (Abdool Karim & Abdool Karim, 2010:373). Being sent to an institution is implemented with the involvement of government in order to meet both children's and carers' needs. In order to ensure that affected children and households both have adequate economic and social protection during ill health and unemployment, their financial and material needs may be secured in form of social security.

4.4.6 Social Security

This section offers a brief discussion of the various types of social assistance made available to all South Africans and the administration and management of grants in order to assure effective service delivery to HIV and Aids-affected households in order to strengthen the capabilities of these families to cope.

Social Security refers to the Social Assistance Act No. 13 of 2004 and the Security Agency Act No. 9 of 2004 that affirm that all South African children may obtain payment of social grants and that these services need to be administered and managed to assure effective service rendering to all South Africans. The White Paper for Social Welfare (1997) recommends an integrated and comprehensive system of social services facilities, programmes and social security to promote social development, social justice and the social functioning of people.

4.4.6.1 Social Assistance Act (2004)

The government provides social assistance to people with disabilities and to parents and children who are unable to provide for their own needs. In terms of the Social Assistance Act No. 13 (2004), social assistance is support given in the form of a social grant or social relief of distress. According to section 4 of this Act, various forms of social assistance are available in South Africae. However, for the purpose of this study, the grants discussed are focused on the child support grant, the care dependency grant, the foster child grant, the disability grant and the grant in aid. Eligibility for the different grants is discussed below, accompanied by Table 3.1 that presents the amount of each grant.

4.4.6.2 Child Support Grant (CSG)

Section 137(c) of the Children's Act No. 38 of 2005 allows children over 16 years to take on a care giver role for younger siblings in the household and such children are therefore entitled to apply for and administer a child support grant in order to meet the basic needs of the household. The latter is not indicated in the 2004 Social Assistance Act. Furthermore, according to Budlender et al. (2008:8), the carer or responsible person does not have to be the biological parent, but proof that she is the primary care giver to children under the age of 18 years is required and the amount varies every year (see Table 3.1). It is a grant that is given monthly in order to alleviate poverty and to meet the basic needs of children (http:/www.childrenCount.org.za/indicator.php).

4.4.6.3 Foster Child Care Grant

A family member or non-family member who is found fit to take responsibility for a child in need of alternative care due to abandonment or to being orphaned is eligible to qualify for this grant (Budlender et al., 2008:37). Section 18d(1) of the Children's Act 38 of 2005 refers to a child in foster care as a child that is placed by the children's court. The foster parent does not have to be related to the biological parent and may foster six children. Furthermore, the involvement of the Department of Social Development is vital in assessment in order to ascertain whether the children will be placed in good care, as well as to monitor for possible family unification. Section 5 of the Social Assistance Act 13 of 2004 requires the foster parent to be a South African citizen. Section 8 requires that the child should be a child in need of care and meet the requirements of the Children's Act 38 of 2005. Hence foster placement in South Africa is often practiced as a cultural norm for maintaining a close family un it, specifically in the case of placements with grandparents (Abdool Karim & Abdool Karim, 2010:384).

4.4.6.4 Care Dependency Grant (CDG)

Section 7 of the Social Assistance Act 13 of 2004 grants that a parent, foster parent or primary care giver of a child who receives and requires permanent care or support services, due to his or her physical or mental health, may qualify for access to a care dependency grant on behalf of that child. A person who becomes infected with HIV usually goes through various clinical stages that occur over a long period of time or, in some people, soon after infection (Johnson & Pizzi, 1990:23). The physical consequences of HIV and Aids from parents for HIV and Aids-infected children are severe and may lead to disability, pain, disfigurement and cognitive impairment resulting in total dependency (Foster et al., 2005:96). Such children may still survive and grow into adulthood, which means that they will then qualify for a disability grant.

4.4.6.5 Disability Grant

According to section 9 of the Social Assistance Act 13 of 2004, a disability grant is granted to a person who is over the age of 18 years who, due to his or her physical or mental disability, cannot perform any work towards generating an income. A disability grant may be permanent or temporary, depending on the person's medical condition. The availability of Antiretroviral treatment which is aimed at prolonging life and lessening symptoms complicates permanent access to disability grant for HIV and Aids patients (Abdool Karim & Abdool Karim, 2010:287).

4.4.6.6 Grant in Aid

HIV and Aids is a progressive illness which may lead to total deterioration in terms of becoming bedridden and dependant on people for daily activities. Section 12 of the Social Assistance Act 13 of 2004 requires a person who qualifies for such a grant to be physically or mentally in a condition that requires another person's assistance.

Applying for these grants is a lengthy process and approval cannot be predicted. Families however rely on approval of this grant.

4.4.6.7 Social Relief of Distress

Section 13 of the Social Assistance Act 13 of 2004 recommends that a grant for social relief of distress be given to those who qualify according to set criteria. A social relief of distress grant is availed to those applicants who are awaiting payment of an approved grant. It is a grant given for three months and may be extended in exceptional cases. It is given in the form of a food parcel or voucher to buy food, although some provinces avail this form of assistance in cash (https://www.westerncape.gov.za/service/temporary-payment-crisis-social-relief-distress-award). The table below presents the types of grant and the amount paid out for each grant.

Table 4.2: Amounts of Grants as at 01 April 2016

Grant type	Amount payable 01 April 2015	Amount payable 01 April 2016	Amount payable 01 October 2016
Care dependency Grant	R1410.00	R1500.00	R1510.00
Child Support Grant	R330.00	R350.00	R350.00
Disability Grant	R1410.00	R1500.00	R1510.00
Foster Child Grant	R860.00	R890.00	R890.00
Grant in Aid	R330.00	R350.00	R350.00

Source: South African Social Security Agency (SASSA). You and Your Grants 2016/201

These grants consist of a monetary contribution by government to promote the welfare of South African children and their carers to preserve and strengthen families. According to sections 3 and 4 of the African Social Security Act 9 of 2004, in accordance with the best interest of the child, there is commitment to the efficient and effective management and administration of these grants to prevent fraudulent action. In South Africa, as from April 2006, the management, administration and payment of social assistance grants have been managed by the South African

Social Security Agency (SASSA) in order to ensure that social grants are paid out to the eligible person at a pay point that is convenient to the person (www.sassa.gov.za you and your grants 2016/2017).

It is clear that South Africa's initial response to HIV/Aids policies and legislation in order to combat and alleviate poverty to HIV and Aids-affected households was first initiated after the first democratic elections in 1994.

4.5 SOUTH AFRICAN GOVERNMENT RESPONSE TO HIV AND AIDS

HIV and Aids were first diagnosed in South Africa in 1981 and the first AIDS related deaths occurred at that time. This period was shaped by government's slow response due to various reasons, like too little knowledge, denial and others. However, there was a strong belief that behaviour was a major cause of the epidemic. Thus, the South African government's only response during the 1980s and 1990s was through providing condoms, safe sex education as well as information through plays like Sarafina in order to change people's behaviour (Simelela & Venter, 2014:249). A home-based care strategy for people in the advanced stage of HIV and Aids and for affected children was also implemented in order to alleviate the consequences of HIV and Aids infection.

In 1992 the South African government realised that the full participation of the community was needed in fighting the HIV and Aids epidemic. Hence NACOSA, the Networking HIV/AIDS Community of South Africa, was established through cooperation between the various trade unions, political parties, academics, scientist, religious organisations, NGOs and many more in order to work on a strategy to fight the HIV and Aids epidemic (Kauffman & Lindauer, 2004:48). This led to the formulation of the National AIDS Plan (1992) that focuses on education and prevention, counselling, health care, human rights and law reform and research (Marais, 2000:12).

It is evident that the National AIDS Plan (1992) paved the way to an integrated plan for the South African government on how to respond to the HIV and Aids epidemic.

4.6 THE ROLE OF NON-GOVERNMENTAL ORGANISATIONS (NGOS)

Lewis (2007:139-143) and Wallace, Bornstein and Chapman (2007:19-20) summarise the role of NGOs as service providers to those who want, need or seek services that are not delivered or available due to reasons such as inequality, poverty, vulnerability and unavailability, inaccessibility or delay of government services. The South African government as well as the various NGOs have played a vital role in terms of legislation and policies to prevent infection and protect infected as well as affected children and their families, and/ or to alleviate the impact of HIV and Aids on these children and their families.

De Wet (2003:18) noted that many NGOs have been established to address the HIV and Aids crisis in South Africa and have engaged in a variety of forms of service delivery to meet basic human needs such as for food, health care and shelter, to empower people to better meet their own needs, and through participating in the process of policy formation by government in order to advocate for all humans. Social workers in NGOs render services to both rural and urban populations. These services are rendered to those who experience poverty, normally big families, who have no or low income, limited food, low education, or suffer from a disease and experience discrimination (Claiborne, 2004:208). Foster et al. (2005:265-269) confirm that direct services by NGOs to people with HIV and Aids include providing food, material assistance, and health services. Availing houses and paying school fees normally are services rendered by NGOs, as well as playing a vital role in children's safety and supporting affected families in order to care and protect their vulnerable children.

4.7 CONCLUSION

This chapter has presented international, regional and national policies and legislation related to the care and protection of households affected by HIV and Aids. These policies and legislation equally assure that constitutional rights of HIV and Aids-affected households are met in order to enhance and sustain a desired level of functioning globally.

The next chapter offers a review of welfare services mandated by Government and offered by NGOs to households affected by HIV and Aids.

CHAPTER 5:

A REVIEW OF SOCIAL WELFARE SERVICES MANDATED BY GOVERNMENT AND OFFERED BY NON-GOVERNMENTAL ORGANISATIONS TO HOUSEHOLDS AFFECTED BY HIV AND AIDS

5.1 INTRODUCTION

The consequences of HIV and Aids for affected households and international legislation and policies responding to the HIV and Aids epidemic were discussed in previous chapters. South African legislation and policies in response to HIV and Aids were developed from such international legislation and policies that.

This chapter aims to meet objective three of the study which is to describe the social welfare services mandated by the South African government and rendered by social workers in NGOs for meeting the developmental or welfare needs of HIV and Aids-affected households. The appropriate policies are discussed in this chapter to meet this objective. The policies are the White Paper for Social Welfare (1997), the Integrated Service Delivery Model (ISDM) (2006), the Framework for Social Welfare Services (FSWS) (2013), and The HIV and AIDS, and STI Strategic Plan for South Africa 2012-2016. The ISDM (2006:14) and the FSWS (2013:12) further recommended that social welfare services be rendered by various professionals, but recognised that the social work profession plays a major role in addressing the developmental needs experienced by HIV and Aids-affected South Africans. In this chapter the contribution of social work in addressing the needs of HIV and Aids-infected and affected families and children as contained in the ISDM (2006) and FSWS (2013) at the following levels of care or intervention is discussed: prevention and early intervention, statutory, residential and alternative care, reconstruction, unification and aftercare as well as the role and responsibilities of the social workers in NGOs.

5.2 SOUTH AFRICAN WELFARE POLICIES AND LEGISLATION MANDATED BY GOVERNMENT

As discussed in the previous chapter, The South African government has over the years developed a range of policies for service delivery to address the needs of HIV and Aids-affected households. Policies that are of importance to social workers offering services to these families in Non-Governmental Organisations (NGOs) are addressed in the subsequent sections.

5.2.1 The White Paper for Social Welfare

Of importance for NGOs is that The White Paper for Social Welfare (1997) provides a policy framework for social welfare that aimed to adjust past welfare policies and programmes that were "inequitable, inappropriate and ineffective in addressing poverty, basic human needs and the social development priorities of all people" (White Paper for Social Welfare, 1997:4). In addition, its aim was to assure that all citizens who are unable to support themselves should benefit from social assistance in the form of social security (WPSW, 1997:8). As discussed in the previous chapter, The White Paper for Social Welfare (1997) was reviewed in 2013 to focus on the changed socio-economic and political situation. Its aim was also to adjust legislation and policies to develop social welfare services and programmes that would adequately respond to the needs of the poor, those discriminated against and vulnerable groups in society (White Paper for Social Welfare, 1997:2016:138-139). It also focuses on the consequences of HIV and Aids for individuals and families and the psychosocial consequences for affected households.

5.2.2 Integrated Service Delivery Model (ISDM)

Subsequent to the White Paper for Social Welfare (1997) (WPSW), The Integrated Service Delivery Model (2006) was introduced by government to call upon various service providers such as governmental institutions, non-governmental institutions, private organisations and faith-based organisations to each play a role in rendering integrated social welfare services, social security and development services to vulnerable people, such as HIV and Aids-infected households, aiming at prevention, early intervention, statutory intervention/residential/alternative care and reconstruction and aftercare in order to meet the needs of these people (ISDM, 2006:18-19). The figure below illustrates these levels of intervention.

Figure 5.1: Levels of intervention

Source: Integrated Service Delivery Model (2006:19)

These services need to be delivered to meet the basic needs of all those who are entitled to such services. The Department of Social Development (DSD) is constitutionally responsible for the emotional, psychosocial and financial care of those made vulnerable by HIV and Aids and to provide social services to alleviate the consequences of the disease (DSD, 2005:7). Of importance is that social welfare services in South Africa are rendered by government and non-governmental organisations with different histories and involvement in rendering services to those infected and affected by HIV and Aids in the epidemic. These services are monitored by the Department of Social Development.

Furthermore, the Department of Social Development focuses on developmental social welfare services aiming to meet the needs of vulnerable and marginalised people, groups and communities to help them to reach their potential (Streak, 2005:8). Hence prevention, early intervention, a continuum of care and reconstruction and after care services for HIV and Aids affected households are recommended.

5.2.3 Framework for Social Welfare Services

Like the ISDM (2006), the Framework for Social Welfare (2013) also focuses on equality, collaboration and integrated service delivery in order to meet the needs of people at all levels of human functioning (FSWS, 2013:9). Moreover, the Framework for Social Welfare Services (2013:29), like the ISDM (2006), recommends that welfare services should be rendered at a

continuous level of intervention focused on prevention, early intervention, statutory/residential/alternative care and reunification, and aftercare. In addition, these services should focus on people's developmental needs and equip them to reach an optimal level of functioning as well as to attain independency.

5.2.4 The HIV and AIDS and STI Strategic Plan for South Africa

The HIV and AIDS and STI Strategic Plan for South Africa 2012-2016 is the third five-year plan aiming to guide the country to respond to the challenges of HIV and Aids treatment, as well as to respond to the consequences of the epidemic. The AIDS and STI Strategic Plan for South Africa 2012-2016 has two main goals, namely to address social and structural barriers to HIV and STI and to prevent new HIV, STI and TB infection (NSP, 2012-2016:12). The goals of the Social Development Strategic Plan (2010-2015) similarly involve reducing the incidence of HIV and Aids and eliminating its psychosocial consequences. To sum up, The South Africa Strategic Plan intends to prevent new infections, to reduce the incidents of infections and to eliminate the consequences of infection.

5.2.5 White Paper on Families in South Africa

As discussed in the previous chapter, the purpose of the White Paper on Families in South Africa (2012) is to protect and support families through governmental policies and legislation in order to adequately meet the needs of families in all spheres of their lives in order to enhance self-reliance (White Paper on Families in South Africa, 2012:8). The consequences of HIV and Aids for affected households discussed in Chapter 2 clearly indicate that these consequences exaggerate family breakdown and vulnerability. Of importance is that the White Paper on Families in South Africa (2012:42-43) recommends services to be directed to HIV and Aids-affected households with specific focus on all the intervention levels of the ISDM (2006): prevention, early intervention, alternative care and reconstruction, and after care. These services are required to meet the welfare needs of HIV-affected households in order to reach a desired level of social functioning.

The next section examines the nature of support and care services mandated by government policies and rendered by social workers in NGOs. The level of service prescribed by the ISDM (2006) and Framework for Social Welfare Services (2013) are presented to explain each of these levels, as well as the role and responsibilities of the social worker.

5.3 FIRST AND SECOND LEVELS OF SOCIAL WELFARE SERVICES: HIV PREVENTION AND EARLY INTERVENTION

The first two levels of intervention as contained in the ISDM (2006) and FSWS (2013) which social workers at NGOs need to be aware of are prevention and early intervention. These are discussed here.

5.3.1 HIV Prevention

The World Health Organization refers to HIV prevention as practices employed to prevent the spread of HIV (https://en.wikipedia.org/wiki/prevention_of_Hiv/Aids). Starfield, Hyde, Gervas and Heath (2008:50) define prevention as a means to halt the development of a pathological state that includes intervention to limit the progression of the disease at any stage of its course through early intervention. Hence, HIV and Aids intervention services should start with preventing HIV transmission, then providing treatment, care and support and addressing the causes of HIV and Aids and its consequences. From the above definition of prevention it is evident that intervention is attempted at different levels, because HIV is a progressive illness. The following three levels of services are relevant to the prevention and early intervention services offered by NGOs to HIV and Aids-affected households. To demonstrate this, the focus of services is also discussed.

5.3.1.1 Primary prevention

Primary prevention entails services directed at the entire population (Browne, Davies & Stratton, 1999:103). Hence, to address HIV and Aids the main aim of services is to avoid the manifestation of the disease for all South Africans. For the purpose of this study, the focus is on preventing HIV infection of adolescents and adults, because statistics reveal that the highest prevalence of HIV occurs among those in the reproductive age range of 15 years to 49 years and vastly increased from 15.6 percent in 2002 to 18.8 percent in 2012 in KwaZulu Natal and in the Western Cape Provinces of South Africa (National Prevalence Incidence and Behaviour Survey, 2012:43). Prevention and early intervention services for this age group may therefore assist in reducing the number of children that become infected. Guided by the main goals of the National Strategic Plan (NSP, 2012-2016) which are to address social and structural barriers to HIV and Aids and to further prevention of HIV, behavioural and biomedical intervention and prevention of mother-to-child transmission are discussed as examples of services at primary intervention level.

5.3.1.1.1 Testing and counselling as prevention mechanisms

As indicated, the main focus of primary intervention is prevention and early intervention in the entire population in order to eliminate HIV infection (See Figure 5.1). The latter can be achieved through counselling and testing at the micro and meso levels of the ecological perspective, which could be encouraged by social workers at NGOs.

5.3.1.1.2 HIV Testing and counselling for vulnerable groups

The National HIV Counselling and Testing (HCT) Policy Guidelines (2010:11) recommend various circumstances under which HIV testing can occur for the following vulnerable people:

Pregnant women: when a clinical diagnosis is done as part of patient care, when high risk sexual behaviour is evident and at antenatal clinics.

Abandoned babies: when *presenting* with clinical symptoms (National HIV Counselling and Testing Policy Guidelines, 2010:14-16).

Prevention in this regard entails individual counselling and education given to individuals, couples, and pregnant women at the antenatal clinics in groups.

Prevention thus is offered at micro, meso and macro systems levels in terms of the ecological perspective (Nash et al., 2005:54). After counselling, individuals need to be directed to the appropriate institution at macro system level. HIV-positive individuals, for instance, need to be referred to ARV clinics and pregnant women need to be referred to the appropriate clinic, thus linking them with the appropriate resources (Nash et al., 2005:58). According to Kirst-Ashman (2013:110), the role of social workers in these cases could be as an educator or a facilitator in terms of being a facilitator of group work (meso system level) and as a broker when the person is linked to a relevant resource to obtain an appropriate service, for instance a psychologist.

5.3.1.1.3 HIV counselling process for individuals and couples

The individuals or couples that either voluntarily seek HIV testing, or in the case of provider-initiated counselling and testing, need to follow an HIV testing and counselling process. This is to prepare them to deal with the results of testing and to manage the consequences of the results of the testing. It is referred to as **Voluntary Counselling and Testing** (VCT) or **Client-Initiated Counselling and Testing** (CICT). Besides this, **testing and counselling initiated by**

the provider, referred to as Provider-Initiated Counselling and Testing (PICT) can be offered in health centres where the individual presents with clinical symptoms.

The HIV counselling process entails providing information to those who intend or are offered an HIV test, followed by informed written or verbal consent, and providing the results of the test followed by post-test counselling and a continuum of support, care and treatment (Van Dyk, 2012:445). Hence, the National HIV Counselling and Testing Policy Guidelines (2010:25) recommend HIV testing to be performed solely where information about testing and consent has been received. However, the patient should be given the opportunity to refuse or opt out and also needs to be counselled regarding the benefits of counselling to motivate the patient (National HIV Counselling and Testing Guidelines, 2010:48). The National HIV Counselling and Testing Guidelines (2010:48) further warn that no person should be tested without having had an individual counselling session (micro level practice) with a social worker regarding what the HIV test entails, the test procedures as well as the meaning of the test results.

The latter information can only be gained through pre-test counselling.

5.3.1.1.4 Pre -test counselling

According to Van Dyk (2012:445), pre-test counselling is done by social workers or trained counsellors giving someone who is considering testing for HIV all the necessary information and support to make an informed decision and to give consent. The counselling may be client-initiated or initiated by the NGO (provider-initiated). In both cases the process will be the same in terms of being voluntary, getting consent from the client, performed at the best interest of the client based on medical grounds, treatment requirements care and support needs and it needs to be continuous (Ramfolo, Chidarikire, Farirai & Matji, 2011:8). Consequently, informed consent is crucial in order to give clients their results of the HIV test.

5.3.1.1.4 Post-test counselling

HIV testing results may be positive or negative. Van Dyk (2012:275) recommends that both positive and negative results should be communicated by a social worker or trained counsellor to the person through post-test counselling. Information and education regarding safe sex, breastfeeding care, and risk reduction is of paramount importance in order to manage a negative HIV status. Furthermore, persons whose HIV test results are positive need to be referred immediately for a CD4 count, clinical staging and TB screening by service providers of NGOs.

Treatment should also be commenced immediately, irrespective of the persons stage of illness (WHO, 2016:7).

The role of the social worker in counselling and education at this intervention level is continuous, as the aim is giving information about HIV and Aids, ascertaining the risk factors, as well as providing information to deal with both a negative and a positive result. These results can be communicated to the individual, couples, as well as to families. Thus Van Dyk (2012:307-309) recommends that continuous counselling following a positive result is of vital importance for individuals, couples and families as they need emotional support in order to cope with the changes brought about by the diagnosis. These changes may range from role changes, from dealing with multiple emotional experiences such as guilt, anger, fear, from disclosure issues, loss of employment and anger, from blaming each other in relationships and sexual issues to dying. Obviously, social work intervention is offered on both micro and meso system levels of the ecological perspective (Nash et al., 2005:58).

5.3.1.1.1 Prevention of mother-to-child transmission (PMTCT)

The South African government initiated the PMTCT programme requiring all pregnant women or women attending antenatal care to be offered an HIV test. In addition, they should be supported to determine when to be tested, not to be coerced but rather to assert their right to consent and confidentiality. They should be provided with the appropriate service in terms of counselling (The National Consolidated Guidelines for the Prevention of Mother-to-Child transmission (PMTCT) of HIV and Management of HIV in Children, Adolescence and Adults, 2014:22). As a result, the PMTCT programme is a critical and effective medical intervention to reduce the burden of HIV, as well as to prevent deaths in children and mothers more effectively (Coovadia, Goga & Schowater, 2009:12).

Intervention to reduce the risk of mother-to-child transmission includes various options and practices. These practices may involve prevention of further transmission of the disease; most importantly, reducing the number of HIV-infected children and new infections. Equally important is that it may prolong the sick parent and child's life, which is the most important intervention in the best interest of the child and, as an advantage to the parent, to have a negative baby. As indicated previously, one of the modes of mother-to-child transmission is by labour and delivery. Therefore, appropriate interventions during delivery to contribute to prevention

of mother-to-child transmission should also be an option to prevent further transmission (Abdool Karim & Abdool Karim, 2010:201).

The PMTCT programme is aimed at giving the pregnant mother an opportunity for early diagnosis in order to benefit the unborn fetus and avoid contracting the virus, as well as prolonging or saving the pregnant mother's life. Hence counselling and testing is the entry point of early diagnosis. This is discussed below.

Counselling and testing

Social workers at NGOs should note that The National HIV Counselling and Testing (HCT) Policy Guidelines (2010:47-48) recommend all women to be counselled and offered an HIV test routinely, as well as to receive counselling and education regarding the consequences of taking or denying a test. Moreover, these should be done with the patient's consent and assurance of confidentiality. Moreover, The National HIV Counselling and Testing Policy Guidelines (2010:25) recommend that HIV testing is not to be performed where no consent has been received and that the patient should be given the opportunity to refuse it or drop out. However, the patient still needs to be counselled regarding the benefits of counselling so as to motivate the patient for counselling. The latter is in contrast with prevention, as giving some pregnant women the opportunity to opt out may not be in the best interest of the child, as stipulated in section 9 of the Children's Act No. 38 of 2005, which states that, in all matters, the child's care, wellbeing and protection of the child's well-being are paramount. Not allowing women to opt out may result in infringing their right to privacy and this may lead to not attending the antenatal clinic. This may result in putting both the unknown fetus and the mother's life in danger, although there is no evidence to prove that (Chersich, Luchters & Temmerman, 20007:16-17).

It is well established that pregnancy provides women an opportunity to receive antenatal care and, more importantly, HIV-related services, including HIV counselling and testing aimed at preventing mother-to-child transmission, as well as receiving treatment and care (Kalichman, 2007:40). The first session of counselling is when the pregnant women or other women decide to be tested or not and has received information regarding the consequences of the HIV test. This is similar for all pre- and post-test counselling, except that with pregnant mothers a nutritious diet during and after pregnancy is emphasised in order to prevent mother to child

transmission. UNICEF (2014:7) confirms that a poor maternal nutritious state could be a risk factor for mother to child transmission.

Hence the National HIV Counselling and Testing Policy Guidelines (2010:25) recommends HIV testing to be performed solely where information about testing and consent has been received. The National Consolidated Guidelines for PMTCT (2014) and The National HIV and Counselling and Testing Policy Guidelines (2010) require that all women be provided with the information about pre-test counselling, post-test counselling and HIV-positive result counselling which will be discussed next.

HIV Pre-test Counselling

All women should be given routine information about HIV testing and the prevention of mother-to-child transmission, safe sex, family planning and the use of contraceptives, maternal nutrition, new-born care and feeding options, the importance of delivering in health care facilities, and the importance of couple counselling and disclosure. Liamputtong (2013:182) emphasises the benefits of couple counselling and disclosure as it benefits both partners, as well as the unborn baby because those parents then tend to take more responsibility for their health. However, this author mentions that ten percent of African men still prefer to go for an HIV test on their own and not to be controlled by their partners.

It is evident that pre-test counselling is aimed at preventing mother-to-child transmission, as well as preparing the person for the outcome of the results, which is done in the post-test counselling session, which is discussed next.

HIV Post-test Counselling

Counselling after testing will depend on the outcome of the test, which may be negative or positive. Post-test counselling with patients therefore should take place for both positive and negative results (Van Dyk, 2012:275). It is recommended that pre- and post-test counselling are done by the same person to make it possible to revisit the pre-test counselling information and reinforce lost information before disclosing the results of testing (National HIV Counselling and Testing Policy Guidelines, 2010:49). The information for a negative result differs from that for a positive result.

The National Consolidated Guidelines for the prevention of mother-to-child transmission of HIV (PMTC) and the management of HIV in children, adolescents and adults (2014:23), as

well as the National HIV Counselling and Testing Policy Guidelines (2010:48) refer to an HIV negative result as a tremendous relief to a pregnant woman. However, pregnant women are also entitled to receive continuous antenatal care, as well as being offered a repeat test at 32-34 weeks of pregnancy, at labour or delivery, and after birth. Furthermore, information and education regarding safe sex, breastfeeding care and risk reduction is of paramount importance in order to maintain a negative HIV status.

There, obviously, are pregnant women who normally may not visit the antenatal health centres and therefore will not access the PMTC program, either because they decline the HIV-testing offer or because programmes are not available in their communities. These pregnant women are normally tested immediately after discovering that they are pregnant and visit a health care centre and are then offered PMTC prophylactic ARV till discharge (The National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTC) and the management of HIV in children, adolescents and adults, 2014:40). However, if they still refuse to be tested, the baby will be tested after birth and routinely followed up with tests (Chersich et al., 2007:16). By doing this, the best interest of the child is once more respected. Hence, the Children's Care Act 38 of 2005 recommends that it is of importance that the principle of the best interest of the child is applied in all matters concerning the child's care, wellbeing and protection.

HIV positive result counselling

The Department of Health (2010:26) recommends that all HIV-positive women should have their CD4 count taken immediately after getting to know that they are pregnant, preferably at the day of their first visit to the clinic. Thus the World Health Organization revised its ARV guidelines to stress commencing ARV treatment immediately to all pregnant women to eliminate mother-to-child transmission and maternal death (WHO Global Update on HIV Treatment, 2013:11). The main idea in conveying a positive result to pregnant women is to reinforce the information given during pre-test counselling, to encourage continuous clinic attendance in order to avoid possible mother-to-child transmission, encourage adherence to treatment and disclosure to their partner and family for further support (Ramfolo et al., 2011:8). However, HIV pregnant women may refuse pre-test counselling, thereby eliminating the child's chances of survival, or some may even consider terminating the pregnancy. It should be noted that, according to the Bill of Rights in the South African Constitution (1996), section 9(3), pregnant HIV-infected women, like all other South African women, have a right not to be

discriminated against as well as a right to health care services including reproductive health according (section 27(1a)). HIV-infected women thus have a right to plan their pregnancy, or to terminate their pregnancy if they wish to do so. However, it is a difficult decision to make and requires counselling to guide them, giving information about termination of the pregnancy and further assisting them during the emotional trauma that follows (Doyal & Doyal, 2013:119).

In this regard the role of the social worker is crucial, because pregnant women should be guided for saving children's lives, as unborn fetuses do not have rights in South Africa. Thus the social worker has to play an active role in counselling and education, as well as in advocating for the rights of the mother, the couple or the unborn fetus. The social worker has to educate the mother or the couple about the importance of going for an HIV test in order to prevent mother-to-child transmission, the importance of Antiretroviral treatment during pregnancy and after pregnancy for both her and the baby, adherence to treatment and her right to termination of the pregnancy when it is legally considered. The mother's option to give birth through caesarean section, and its benefits and information on breast feeding and a nutritious diet to limit the chances of transmission should also be conveyed (Van Dyk, 2012:304:305). The role of the social worker entails continuous counselling, education, and advocating for the unborn fetus. This kind of intervention is at micro, meso and macro levels of the ecological systems perspective as the social worker has to provide information based on the mother or couple's rights (Pardeck & Pardeck, 1988:134).

It is clear that both prevention and treatment are priorities in order to save lives or in reducing the consequences of HIV and Aids. For the purpose of this study, prevention and early intervention is focused on a combination of biomedical and behavioural intervention methods at primary, secondary and tertiary levels of intervention in order to meet desirable outcomes. This is in line with the main goals of the NSP 2012-2016, which are to address social and structural barriers to HIV and Aids, and early prevention intervention in HIV testing, and TB screening followed by treatment, care and support.

UNICEF (2012:6) recommends targeting women of child-bearing age in order to avoid unintended pregnancies which' in turn, will reduce the number of children born with HIV and improve maternal health. Chersich, Luchters and Temmerman (2007:15) and UNAIDS (2011/2012:10) confirm that early intervention through effective family planning and education for both infected and affected mothers is another kind of service that NGOs can offer to reduce the number of infected children. There are also other biomedical and behavioural prevention

interventions, like male circumcision and male and female condoms that are utilised prior to medical intervention and may continue to be used. These interventions are discussed next.

5.3.1.1.7 Biomedical and behavioural prevention methods

One of the aims of the HIV and AIDS and STI Strategic Plan for South Africa 2012-2016 is to prevent both sexual and vertical transmission of HIV and STI (Sexually Transmitted diseases) by increasing access to medical male circumcision for adults and neonates, as well as to promote the use of both male and female condoms.

Male Circumcision

Male circumcision is one of the most common surgical procedures done for medical and traditional reasons where the latter is seen as an integral part of manhood (Van Dyk, 2012:54). The Children's Act No. 35 of 2005 section 5(1) allows circumcision of a male child over the age of 16 years, with consent after proper counselling by a parent, guardian, carer or social worker. It has been proven in three randomised controlled studies conducted in Sub-Saharan Africa in 2007 that male circumcision is effective in reducing the risk of sexual transmission of HIV from men to women by 60 percent (WHO/UNAIDS, 2011:63). Other studies also reveal that the majority of male circumcisions were performed for traditional purposes with the highest population of 83.1 percent in the Eastern Cape (HSRC, 2014:60). Thus Van Dyk (2012:55) recommends that social workers should be aware of cultural diversity in order to be sensitive when dealing with such issues, as well as of their own cultural and religious belief when promoting medical circumcision.

Some men refuse to be attended to by female doctors or nurses as they fear that females may to talk about them performing the procedure. A study on medical male circumcision in South Africa that was conducted in 2010 revealed that circumcised men may experience rejection from their peers, that they may not be regarded as a real man, and that they may not address other men or may not attend ceremonies (Soul City Institute, 2010:15-16).

The role of the social worker in this regard is to offer continuous counselling and education about medical circumcision, to support and respect men's views, as well as to assist them in dealing with the stigma they experience (Behrens, 2014:16). The social worker should also assist them in dealing with the fears that they experience prior to the procedure; fear of pain,

death and losing erection should something go wrong were a few of challenges arose from the study (Soul City Institute, 2010:12).

Male and female condoms

Because the safety of sex cannot be guaranteed, consistent and proper use of both male and female condoms may prevent the spread of HIV (The Global AIDS epidemic, 2004:13). Scholars like Abdool Karim and Abdool Karim (2005:51) and Stine (2012:245) confirmed that the use of male and female condoms have both been proven to prevent the transmission of HIV, STDs and pregnancy or unintended pregnancies by 86 percent to 97 percent.

The male condom programme in South Africa was introduced by the National Department of Health in 1992 in response to the HIV and Aids epidemic, at no cost (Abdool Karim & Abdool Karim, 2005:167). However, the female condom to be used in conjunction with the male condom to increase safe sex was only approved in South Africa in 2003 by the food and drug administration (Abdool Karim & Abdool Karim, 2010:293). The female condom has many of the same benefits as the male condom. In addition, it allows women to take independent and more active responsibility in preventing pregnancy. Of importance is that it covers a greater part of the labia, which ensures greater protection, as well as being convenient to insert long before sexual intercourse (Stine, 2012:249). However, despite the introduction of the female condom women still are not always in a position to negotiate condom use because sexual intercourse is often male initiated. This can consequently lead to sexual violence, and to an increased risk of HIV infection in South Africa.

It is therefore vital that a non-barrier method, which could allow women full control over safe sex without their husband's knowledge be developed in order to effectively implement one of the aims of the HIV and AIDS and STI Strategic Plan for South Africa NSP 2012-2016, which is to implement intervention to deal with gender norms and gender-based violence. Hence Strategic 4 of the NSP 2006-2011 recommended protection of human rights and improved access to justice.

The social worker's role is to counsel and educate individuals or couples and groups about effective condom use in order to prevent infection, empower women to be able to negotiate condom use with their partners, and, most importantly, to deal with the various myths of condom use through intensive education. Kirst-Ashman (2013:39) mentions the existence of

common myths, such as that a real man does not use condoms, it inhibits erection and pleasure and that it spreads HIV and Aids.

In most African cultures, women are expected to be obedient to their husbands in many ways which include not denying her husband sex and not initiating condom use as it may lead to domestic violence as well as being left by her husband for another woman. Thus the social worker needs to empower women to be able to negotiate safe sex with their husbands and educate them about their rights in terms of condom use. Intervention in this regard is on micro, meso and macro system levels.

In addition to these discussed biomedical and behavioural prevention/intervention methods, community awareness programmes are also of importance in order to educate South Africans regarding prevention of HIV and Aids infection. It will also be of benefit to reach youth on the streets who normally become sexually active at an early stage for a variety of reasons.

5.3.1.1.8 Community Awareness Programmes

The second objective of the South African National Strategic Plan on HIV, STIs and TB 2012-2016 entails the implementation of a comprehensive national and social change communication strategy with specific focus on key populations. The key populations for this study are women, children and the youth (South African National Strategic Plan on HIV, STIs and TB 2012-2016:15). The Framework for Social Welfare Services (2013:21) recommend social welfare services to be rendered to all South Africans, specifically to vulnerable groups like people who are living with HIV and Aids, children and the youth.

In order to successfully prevent the spread of HIV, changing behaviour through increasing people's knowledge of the disease and changing their attitudes towards HIV is fundamental (UNAIDS, 2006:30). Van Dyk (2008:129) and Rohlender et al. (2009:276) explain that HIV and Aids education is the optimal prevention intervention method for changing behaviour and attitudes, as well as for empowering the community with skills and motivating them to practice safer sex.

A particular group of children who need protection services in order to prevent them from contracting HIV and Aids are those children living on the streets, who, in most instances, escape poverty at home, run away from abuse at home and those who live on the streets without any no parental care. These children tend to be vulnerable to abuse (Kruger & Richter, 2003:4).

They tend to fend for themselves due to a lack of parental care and protection. As a result, they become vulnerable to sexual exploitation and engaging in sexual activities for survival with multiple partners at a younger age and without the use of condoms (Rotheram-Borus et al., 1991:230). These young children consequently become vulnerable to HIV infection for lack of information about available services and the risks of early sexual engagement. Youth engage in sexual activities in order to survive or sometimes purely because of curiosity and experimentation (UNAIDS, 2004:93).

Youth, in addition to protection services, need peer support or education about health to be equipped with knowledge to debate and negotiate best behaviours to make the best decisions for themselves to enable prevention of HIV infection, as needed (Van Dyk, 2008:130). UNAIDS (2004:95) confirms that prevention through education and knowledge are of importance in order to allow young South Africans to take full responsibility for making the choice of not becoming infected. Abdool Karim and Abdool Karim (2005:281), however, state that education and knowledge alone is not sufficient to generate long-term behaviour change. They point out that it should be supplemented with other interventions such as access to prevention methods like condoms, as well as addressing the causes of the HIV epidemic in young South Africans. The youth need not only to be protected from HIV, but also need to develop basic life skills to enable them to take charge of their futures.

Community awareness programmes provide social workers with the opportunity of being involved in community work, and to work with other stakeholders and other professionals in offering outreach projects to the population. In this way, social work prevention services can be directed to those children and youth living on the streets, drug users, prostitutes, school drop outs and the entire population. These services can be carried out in public places such as libraries, pharmacies, hospitals, and shopping malls. The social worker's role in this regard is to offer counselling and education (Strug et al., 2002:8).

In addition, the social worker may initiate these community awareness programmes in collaboration with other professional role players. They therefore need to make contact with other professionals, need to make a proper assessment and motivation for planning the programme and for finding sponsors to support the programme. In this, the social worker's roles and responsibilities include being a broker, as the social worker is working with professionals in other organisations as well as networking with them. Besides, social workers should also act as enablers to motivate HIV and Aids-infected and affected people to be

involved in these programmes. As advocates, social workers should refer people to relevant resources after HIV testing. As mobilisers, they could organise fund raising in order to sustain an HIV programme, for instance in the particular hospital which community members use, and in all of this they also act as administrators (Berg-Weger, 2010:281).

There is a wide range of national and provincial HIV and Aids community work programmes in South Africa. These programmes are conducted by government and non-governmental organisations (NGOs) by means of education at schools, universities, and departments of health, and also by means of community-level campaigns such as door-to-door activities and events such as around World Aids Day and events in workplaces (Shisana et al., 2009:58). A number of national non-governmental organisations conduct community work activities at national level. The most prominent programmes and campaigns run in South Africa include Khomanani, Soul City, Soul Buddyz and Love Life. These campaigns are discussed below.

Khomanani Programme

Khomanani ('let us work together') is a primary national HIV and AIDS programme in South Africa (Parker, Rau & Peppa, 2007:53). This programme is conducted by the Department of Health and activities are conducted through mass media; promotional events such as World Aids Day; and Candle Light Memorial Day for those infected and who died of HIV and Aids (Shisana et al., 2009:58). The activities are about ABC abstinence (**A**bstinence, **B**e Faithful, and use **C**ondoms) on most prominent interactive television talk shows with a specific focus on youth and focusing on messages conveying VCT, STI and treatment, couple testing, distributing condoms of choice, promoting care that includes Antiretroviral therapy (ART) care, and support for orphans and vulnerable children.

Soul City and Soul Buddyz Programme

The Soul City programme was initiated in the early 1990s and focuses primarily on adults. The Soul Buddyz programme was initiated in the early 2000s (Grannis, 2011:79). It focusses on children of the ages between eight and twelve, which is an appropriate age to start education about HIV and Aids. These programmes address HIV and Aids-related topics and provide information about ARVs and living positively with HIV. This is offered through booklets, television and radio talks (Parker et al., 2007:53).

Love Life Programme

Love Life is a national HIV and Aids programme for youth, launched in 1999. The programme is for youth and focuses primarily on pre- and newly sexually active adolescents between the ages of 12 to 17 years (Shisana et al., 2009:59). The campaigns are offered through television and radio programming, broadcasting, advertisements, billboards and promotional items, which provide a contact number for help around sexual and reproductive health, sexuality and HIV and Aids. Additional activities and events include a youth magazine, Scamto, Uncut, love trains and youth centres, all of which focus on awareness (Parker et al., 2007:54; Shisana et al., 2009:59).

It is evident that primary intervention focusses on prevention and early intervention. However, it also becomes evident that both primary and secondary interventions are often utilised together, as it cannot be separated. The reason for this is to prevent new infections, as well as to prevent maternal death. For this, the social worker's role is mostly focussed on counselling and continuous education. From an ecological perspective systems intervention is offered on micro, meso and macro levels in order to meet the holistic needs of HIV and Aids-affected households (Hall, Byers, Qiang & Espinoza, 2007:55).

Admittedly, conveying knowledge and education plays a tremendous role. Similarly, education in prevention of HIV infection is of a continuous nature, as after being diagnosed with HIV, and not having utilised prevention measures, the latter may lead to pregnancy, as well as a high risk of becoming infected and transmitting the virus to the unborn fetus. The next section will discuss secondary prevention.

5.3.2 Secondary prevention

In addition to primary prevention services, NGOs may offer secondary prevention services to families who may be at risk of HIV infection and those who are affected and therefore are in the hope of eliminating or reducing the consequences of the disease (Pomeroy & Steiker, 2012:102), programmes that are needed obviously have to be focused on eliminating child death and keeping mothers alive. Examples of the nature of secondary prevention will be discussed in the section below.

5.3.2.1 Antiretroviral Treatment in Pregnancy

Statistics South Africa (2013:1) reveals that the total population in 2012 was estimated at 52 million people and 18.6 million were children under 18 years of age. South Africa has the largest number of HIV-infected individuals in the world, as well as the largest number of patients who started ART in 2012. This is estimated to be 376,000 people and was expected to reach 3.1 million by 2015 (Bekker et al., 2014:105). UNAIDS (2002:128) has recommend that the entry point for preventing HIV in children is with parents during the reproductive age of women and their partners. As discussed previously, HIV counselling and testing provide the core service for preventing mother-to-child transmission. This is because it benefits both the client and the health system, because it enables early access to treatment, support and care (Evian, 2011:328). Thus the 2013 WHO Global Update on HIV treatment recommended early and immediate initiation of antiretroviral treatment at a CD4 count of 500 or less to pregnant women living with HIV, for all children younger than 5 years, and for pregnant women irrespective of their CD4 count.

A Progress Report on the Global Plan (2012:6) of UNAIDS recommend the establishment of a comprehensive global plan towards eliminating new infections for keeping the mothers alive through fast tracking pregnant women and their children from the time of pregnancy until the mother stopped breastfeeding. The latter can only be in the best interest of the child by means of early intervention with the pregnant mother through counselling and testing. Thus, The Children's Act No. 38 of 2005 section 9 stipulates that in order to meet the principle of the best interest of the care, protection and wellbeing of the child, this elimination of infections needs to be applied at all times. Consequently, in order to be able to protect or prevent children from contracting the virus, both pregnant mothers and their babies need to access high quality services along a continuum of care from pregnancy through child birth and the postnatal period until the child proves to be HIV negative (UNICEF, 2012:7). It has also been estimated that South Africa has the highest prevalence of children born to HIV infected mothers each year, at 300,000, with about 93,000 of these babies infected with HIV, of which 72,000 will be HIV-infected at birth and 21,000 will notably be affected through breastfeeding (UNICEF Progress Report, 2014:28). Furthermore, more than 200 children under the age of five years die daily due to preventable diseases, like HIV and Aids-related diseases, followed by pneumonia, diarrhoea, under nutrition, and childhood vaccination (UNICEF, 2014:1). NGOs need to be

aware of the following ways in which HIV transmission can occur in order to make efforts to prevent this.

5.3.2.1.1 HIV Transmission during birth and labour

The Unicef Progress Report (2014:41) conveyed that, despite progress made globally in preventing maternal and child death, 289 000 mothers die, 2.6 million still births occur and 2.8 million babies die in the first month of life, mainly due to inadequate care during pregnancy and delivery. Traditional births that normally take place at home and are supervised by a well-trusted female family member have been identified as a mode of transmission of HIV as the baby is normally forcefully pulled from the womb (Mchunu & Bhengu, 2004:41).

Moreover, the three top causes of maternal death are non-pregnancy related infections, obstetric rapture and hypertension that occurs in day and tertiary hospitals as reported in the (Africa Health Review, 2012/13:51; Republic of South Africa, 2012/2013). Abdool Karim and Abdool Karim (2010:201) explained that premature rapture of membranes and intervention during delivery also contribute to mother-to-child transmission. What is more, hospitals where this occurs mainly render services to those who are unemployed, from poor communities and marginalised, and struggle to access adequate services and treatment. As a result, the children they give birth to continue to live in such poverty. Of importance, however, is that HIV transmission can be reduced with the utilisation of a combination of ART, elective caesarean section and avoidance of breastfeeding. Based on the information discussed earlier in this chapter it is well established that HIV can also be transmitted from mother-to-child. An estimated 1.5 million pregnant women were living with HIV globally in 2013 and about 90 percent of infections in infants and children were transmitted from the mother to the child during pregnancy, delivery or breastfeeding (http://data.Unicef.org/hiv-aids/cmtct 2015:1). The risk of in utero transmission in untreated women is related a high viral load and a low CD4 count (Abdool Karim & Abdool Karim, 2010:201).

From the above discussion it can be concluded that preventing mother-to-child transmission can prevent HIV transmission to the unborn child. Thus, HIV testing at antenatal clinics is of vital importance in order to prevent mother-to-child transmission, as well as early maternal death. For both planned or emergency caesarean section delivery, antiretroviral prophylaxis should be administered prior to the procedure (National consolidated guidelines for the prevention of mother-to-child transmission of HIV and the management of HIV children,

adolescents and adults, 2014:48). Thus it is strongly recommended that the mother should be counselled after birth and receive education about alternatives to breastfeeding.

5.3.2.1.2 HIV transmission during breastfeeding

Prolonged breastfeeding doubles the risk of mother-to-child transmission. While a total prevention strategy is avoiding breastfeeding and mixed feeding (i.e. milk and formula or other substances) which also has a higher risk of transmission than exclusive breastfeeding (Rohleder et al., 2009:187). Further risk factors are poor health of the mother's breasts, such as cracked nipples or abscess, her maternal nutritional status and the child's oral condition, like the presence of thrush (UNICEF, 2014:7). A study from South Africa reveals that exclusive breastfeeding caries a significant lower risk of HIV infection than mixed breastfeeding (WHO 2005:14; Abdool Karim & Abdool Karim, 2010:205). However, HIV-positive women have feeding options such as exclusive breastfeeding or mixed feeding, formula feeding and many more which, in the South African context, is not always feasible due to poverty and unemployment. This does not enable women to maintain the option consistently (UNAIDS, 2002:15). With HIV and Aids nutrition is therefore fundamental for both the mother and the baby.

5.3.2.2 Nutrition and HIV and AIDS

All national policies and legislation discussed above focus on the rights of the child and the family. Furthermore, they emphasise the fundamental role and responsibilities of the government, carer, and family members in meeting the basic needs of children and families with specific focus on the best interest of the child at all times. Therefore, the main focus is on the right of the child and the family to food, shelter, health care, housing and poverty alleviation, to mention what is most important.

Article 10(2) and Article 11 of The International Covenant on Economic, Social and Cultural Rights (1966) recommend that what is needed for an individual and his or her family to have an adequate standard of living are adequate food, clothing and housing with continuous improvement of these standards of living. The mother's health and nutritious status is of importance during pregnancy because it will determine the child's HIV status at birth, the child's growth and developmental stages, as well as the mother's health (Piwoz & Bentley, 2005:2). The latter is in line with the Millennium Development Goals (2000) that aim at eliminating infant deaths and keeping mothers alive. Piwoz et al. (2005:3) further recommend

the daily intake of proteins in order to improve weight gain and increase the immune system which would result in reducing the risk of premature births and mortality rates.

Finally, women comprise one of the most vulnerable groups of individuals in terms of becoming HIV-infected, as already indicated in both previous chapters. In addition, women play a fundamental role in caring and nurturing the entire family. As a matter of fact, Article 10(2) of The International Covenant on Economic, Social and Cultural Rights (1966) guarantees special protection for mothers before and after child birth.

Haddad and Gillespie (2001:495) explain that nutritional deficiency may result in immune suppression and lead to disease progression. Hence, good nutrition or nutritional status and vitamin supplements may lead to delayed onset of and death caused by HIV infection. Although much has been done to prevent mother-to-child transmission, the risk of transmission of the virus remains evident. Therefore, it is important to test children of an HIV positive mother after birth, as well as to test the child for clinical symptoms, as for adults. This is necessary because HIV infection in children is through mother-to-child transmission, the main infection route, during pregnancy, delivery and breastfeeding (Bor & Elford, 1998:238).To sum up: Mother-to-child transmission can be avoided through intense education offered by NGOs working in the field of HIV and Aids regarding the consequences of breastfeeding and caesarean sections. Thus it can be concluded that both biomedical, structural and behavioural prevention intervention need to be utilised in order to achieve effective results.

The role of the social worker is to provide counselling to pregnant mothers and their partners, as well as to groups of pregnant mothers with their consent. The information given needs to focus on the antiretroviral prophylaxis that will be administered to the mother during pregnancy, its effects on the unborn baby, and the side effects thereof. Further education is needed about adherence to the ART treatment after pregnancy in order to prolong the mother's life, as well as the importance of taking the medication as prescribed for effective results. The mother should also be educated about the need for a nutritious diet during and after pregnancy. The social worker furthermore needs to provide education regarding family planning to assist the mother in making informed reproductive choices, as reproductive choices are often made by males in many African cultures. The importance of giving birth at a health facility in order to minimise transmission risks should also be discussed (Strug et al., 2002:9-10).

Equally important is that, the social worker also needs to refer pregnant women to resources that can provide them with food parcels during and after birth to ensure that both the mother and her family have access to a nutritious diet. Spencer, Harman, Naicker and Gohre (2007:35) emphasise that family food support should be provided by both government and non-governmental organisations and that assessments need to be done by the social worker who should also assist the family with the application for welfare grants. Intervention should be focused on the individual, the couple and on groups, therefore intervention comprises micro and meso systems intervention.

In conclusion, it is evident that postnatal care for the mother and baby is of utmost importance as it provides an ideal opportunity to check for danger signs such as insufficient feeding and fever. Mothers can receive advice on how to identify and respond to these symptoms. At the same time, as well as receive information about breastfeeding. Without proper postnatal care there is strong chance that a child born to an HIV-positive mother may be HIV positive. Hence, these children also need to be tested and be treated accordingly. Tertiary prevention is discussed in the section below.

5.3.3 Tertiary prevention

For tertiary prevention, services should be directed to those who are already identified with the problem and who are hoping to avoid future recurrence (Pomeroy & Steiker, 2012:102). According to the Framework for Social Welfare Services (2013), continuous care services to HIV and Aids-affected households is of major importance to reduce child mortality and keep mothers alive through early treatment intervention and promoting adjustment to irreversible conditions and consequences. Thus the role of the social worker is to provide education and information. With mother-to-child transmission being one of the major causes of HIV infection in children it is of paramount importance to test infants to ascertain that they are not HIV positive, but, if so, to be treated accordingly. The next section focuses on HIV testing and counselling of children.

5.3.3.1 HIV testing and counselling of infected carers of affected infants and children

The Children's Act (No. 38 of 2005:4) refers to a child as a person aged 0-17 years. Children form the core of any society as they are the future faces of the country. They need to be protected and saved from harm. Thus the South African Constitution (Act 108 of 1996) includes a Bill of Rights which lists basic human rights for all South African citizens, including people living

with HIV and Aids. Children's right to basic health care services are a basic human right under section 28(1c) of the South African Constitution. Furthermore, the best interest of the child and care and protection is of paramount importance (Children's Care Act No. 38 of 2005 section 9). Thus Preventing mother-to-child transmission thus is of utmost importance in order to reduce paediatric infection and maternal and infant deaths (UNAIDS, 2012:6). The main aim of The National Strategic Plan (2012-2016:15) is to reduce infant, child and maternal mortality.

HIV counselling and testing of infants and children is essential as this facilitates early diagnosis and treatment for survival (Van Dyk, 2012:279). Counselling at this age is conducted with the mother or carer (Grant, Lazarus, Strode, Van Rooyen & Vujovic, 2012:7). The status of the unborn fetus or child after birth totally depends on the mother's adherence to ART treatment during pregnancy and after pregnancy. As already indicated, the majority of children are infected through mother-to-child transmission. Thus both the National PMTCT Guidelines (2014:23), and the National HIV Counselling and Testing Policy Guidelines (2010:48) recommend continuous antenatal care and a repeat HIV test at 32 to 34 weeks of pregnancy, at labour or delivery, and after birth. Therefore, HIV diagnoses and counselling for or with children is paramount.

The World Health Organization (WHO, 2013:6) recommends early and immediate ARV initiation for all children under the age of five years, as also for pregnant women. Thus section 28(1b) of the Constitution of the Republic of South Africa, 1996 and section 18(2b) of the Children's Act 38 of 2005 guarantee all children the right to family or parental care, and as gives all parents the responsibility to care for their children, as addressed in the next section.

5.3.3.2 Testing affected children

The National HIV Counselling and Testing (HCT) Policy Guidelines (2010:32) recommend testing children when they are exposed to HIV through MTCT; when the child presents with HIV-associated conditions such as severe pneumonia, persistent or recurrent fever, neurological dysfunction; where there is a history of parents dying of HIV/AIDS; when the child is sexually abused; when the child is infected through contaminated needle pricks, infectious blood or blood products; when the child is considered for adoption; or when one wants to find out whether another person has contracted the virus from the child. However, in the latter instance, only the court can give consent, as indicated in section 130(b) of the Constitution (1996) that stipulates that it can only be given when any other person may have contracted HIV due to

contact with any substance from the child's body that may transmit HIV. Similarly, section 130(1a) recommends HIV testing to be solely performed when it is in the best interest of the child. The social worker plays a crucial role in advocating for the child through protecting the child from being tested for other reasons than the child's best interest. The social worker should educate the mother regarding the rights of the child, so as to empower her to be assertive in protecting her child. Payne (2005:298) refers to advocacy as a role to be performed to protect the rights of clients.

The Children's Act No. 38 of 2005 states that a 12-year-old and older child may give consent for an HIV test and recommends that an HIV test to be done only after proper counselling with the child, followed by post-test counselling by an appropriately trained person, such as a social worker (Section 132(2)). Grant et al. (2012:7) suggest that children who are about 7 years old may be involved in the counselling and testing process as they do have the capacity of understanding health and illness issues. Van Dyk (2012:80) recommends that social workers should consider the child's age and developmental stage in order to ascertain the child's level of understanding.

The social worker plays a crucial role in both pre- and post-test counselling through providing information about HIV and Aids and its consequences, preferably in a language that the child understands. The social worker furthermore should assess the child's support system, build a trusting relationship with the child and emphasise confidentiality. In post-test counselling the social worker should also re-emphasise the results provided by the medical doctor or health care worker who conducted the HIV test, address the immediate feelings about the results, and discuss treatment and resources available for further support and care (Grant et al., 2012:16-17).

The 12-year-old or under 12-year-old child may also be granted the right to confidentiality in order for him or her to decide who to disclose to (The Children's Act No. 38 of 2005, section 133(2a)). The benefit of disclosure for children is that the child will gain a better understanding of the illness and its associated factors, like stigma. Thus the child might be more likely to adhere to the treatment, as well as attending a health centre (WHO, 2011:11). Legally, in fact, children's HIV status should be disclosed to them even before they reach 12 years of age. Thus section 133(2) of the Children's Care Act gives the child authority to give permission for his/her HIV status to be disclosed, and states that no person may disclose the child's HIV status without the child's consent. Social workers play a most important role in discussing the consequences

of disclosure with the child and assisting the child in making an informed decision, as well as in playing the role of being a broker as the social worker links the child to relevant resources.

To sum up, it is evident that, according to the first and second level of the ISDM (2006), and the Framework for Social Welfare Services (2013), HIV prevention and early intervention focus on a variety of intervention measures in order to prevent the entire population, and more specifically children and women, from contracting the HIV virus, as well on as utilising Antiretroviral intervention to save and prolong the lives of both children and mothers. Social workers play a crucial role in prevention and early intervention at individual, group and community levels. This is done through counselling, educating, supporting and empowering families as clients require knowledge about the facts of HIV in order to be able to avoid the risk of contracting the virus. They also need to be empowered to take the necessary steps to use condoms, to negotiate condom use, and to be aware of their rights to effectively deal with the consequences of HIV and Aids (Kirst-Ashman, 2013:388). However, because HIV is a progressive illness that often leads to the early death of parents, prolonged ill health of parents and other poor environment factors such as poor finances, most children are impoverished. Thus, in order to meet the needs of these children who are rendered in need of care and protection, statutory, residential and alternative care often becomes essential in order to care for and protect them. The various kinds of alternative care are discussed below.

5.4 THIRD LEVEL OF INTERVENTION: STATUTORY, RESIDENTIAL AND ALTERNATIVE CARE

Statutory, residential and alternative care present the third level of intervention mandated by the ISDM (2006) and the Framework for Social Welfare Services (2013) for the care of those children in need of care. Supporting these children may involve placement in alternative care, followed by reconstruction and aftercare in order to render support services to enable reintegrating the child with his or her family and to enhance optimal functioning (ISDM 2006:19). For the purpose of this study, the focus was on alternative and residential care. The Children's Act 38 of 2005, section 167, refers to a child in alternative care as (a) a child placed in foster care; (b) in the care of a child and youth care centre, and 3(b) with a person, place or premises of safe care only when ordered by the court. It must be noted that placements can only be arranged by social workers employed by non-governmental organisations and those employed by governmental institutions (Social Development) through the court. The available kinds of alternative care are discussed below.

5.4.1 Foster Care Placements

One kind of alternative care is foster care. Section 167 of the Children's Care Act No. 38 of 2005 confirms this as a foster placement. The Children's Act No. 38 of 2005, in section 180 refers to a child in foster care as a child who is placed in the care of a person who is not a family member of the child, who is not the parent or guardian of the child by court order. In South Africa, kinship foster placements are a long-established traditional practice usually provided by immediate family such as grandparents after the death of the mother or parents of the child or when a parent or parents are untraceable (Foster et al., 2005:242-243). In both foster care and cluster foster care the caring role is normally assumed by elderly people. Although the grandparents normally feel that they are obliged to look after their grandchildren, they do not always have the resources to care for these children. This may be because they have died or are not able to do it due to ill health (Blerk & Ansell, 2007:868; Foster et al., 2005:241). These children in need of care are then often placed in foster care with non-relatives.

Budlender et al. (2008:37) confirm that alternative care aiming to provide financial assistance to non-relatives and take responsibility for neglected, abused, abandoned children or children with behavioural challenges has been practised for decades. Blerk and Ansel (2007:865) explain that alternative care in South Africa is pursued due to the consequences of HIV and Aids that result in most families not being able to care for extra children due to financial constraints.

In addition, section 185(1) recommends that six children be placed in foster care with one or two persons who share a common household. Similar to the Children's Act, the 1996 South African Constitution, section 28(1b) endorses the right of every child to appropriate alternative care. Thus cluster foster care can be arranged.

The Children's Care Act No. 38 of 2005, section 185(2) refers to foster cluster care as an instance where more than six children are placed in foster care. Section 183(2) also emphasises the importance of such a scheme to be registered with the head of the Department of Social Development. Furthermore, foster parents receive an allowance in the form of a foster care grant for each child in their care.

The role of the social worker in foster placements is to assess the social circumstances of the biological family to ascertain whether the child is at risk and needs to be removed; to find a suitable place for the child, be it a foster home or family that will meet the child's physical,

emotional and social needs. It is also recommended that the placement be closer to home in order to allow the involvement of the biological parents.

Thus the foster placement is usually followed by continuing services, like making contact with both the family and the child, or with concerned children through home visits, as well as monitoring the child's progress within the new family or at school (Grannis, 2011:131; Kirst-Ashman, 2013).

The social worker also plays an important role in assisting these children individually, as well as in groups, in dealing with their identified challenges, as well as assisting them in adjusting to the new family. The latter is done in cooperation with the foster parents as they also need to be counselled regarding changes and adjustment to the new family member or members in the family (Kirst-Ashman, 2013:298). It is crucial for the social worker to maintain close contact with the biological parents in order to render services to her with specific focus on the reason of the child's removal, whether financial circumstances or inability to perform adequate parental roles and skills due, to for instance, the mother's ill health.

5.4.2 Child-headed households

A second form of alternative care is child-headed households. The Children's Act 38 of 2005, Section 137 refers to a child-headed household as a household where the parent, guardian or carer of the household is terminally ill, has died or has abandoned the children so that. no adult family member is available to take care of the children. Budlender et al. (2008:32) refer to child-headed households as children that live alone due to being orphaned or abandoned, or who are in situations where the adult or parent is terminally ill. In such cases, for instance, a 16-year-old child may be taking care of the adult, as well as the other younger siblings in the household. Budlender et al. (2008:34) also states that a child-headed household has no adult member, and the eldest child takes up the parental role for the younger children in the household. In terms of section 137(2), the child-headed household should be supervised by an adult person designated by the children's court or by an organ of state or NGO determined by the provincial head of social development. Section 135(5) confirms that a child heading a household may collect and administer any social grant or other grants in terms of the Social Assistance Act No. 13 of 2004.

Child-headed households present a relatively new form of alternative care which developed due to the Aids epidemic and concerns were raised regarding the fact that these children were placed with different carers, thus losing contact with families, losing family memories, missing the

opportunity to grieve together, as well as losing the opportunity to have knowledge of their culture and family background (Grannis, 2011:111). Foster et al. (2005:112) recommend that children who had recently lost a parent or parents should be kept intact with their immediate families and siblings in the home environment with which they are familiar. The benefit is that this will assist them in dealing with the death of their parents. The social worker may assist these children with keeping their parent's memories through gathering information about their family from them or from relatives and from pictures, and to let them talk about their family and read it to them at times.

The eldest might be given the responsibility of caring for the younger ones, but the full participation of the younger siblings in any decision regarding their wellbeing should be guaranteed (Singhal et al., 2003:73). The eldest child may be deprived from enjoying his or her full childhood, be unable to further his or her studies and finding it difficult to deal with the challenges encountered with the other siblings. This may cause the child to transfer anger to the younger siblings (Abdool Karim & Abdool Karim, 2010:383). Singhal et al. (2003:74) warn that these children are prone to prostitution in order to earn more money and may end up on the streets due to limited income and food.

The latter situations are in contrast with the Children's Care Act 38 of 2005, section 16 that requires that every child's responsibilities be age appropriate. The 1996 South African Constitution section 28(fii), for instance, states that no child should be expected or required to perform duties or provide services that will put the children's wellbeing, education, physical or mental health or spiritual, moral or social development at risk; and section 29(1) states that every child has a right to primary education. The latter is in line with the CRC and the African Charter.

In cases where it is evident that alternative care for the children will be needed, the social worker's role is that of an educator who has to counsel the biological mother or carer regarding disclosure of her HIV status to her children, so that they may be able to care for and support her properly. In addition, the social worker should educate the children about HIV and Aids to enable them to support the family member, as well as to apply precautionary measures. The social worker also needs to address the financial needs of the affected family by arranging birth certificates for all the children so that they may be able to access the necessary grants and be able to attend school. It should be noted that section 5(3) of the South African Schools Act 84 of 1996 mandates that no child should be refused admission to school if their parents are unable

to pay school fees. In these cases, the social worker should advocate for them for school fee exemption, and also refer them to resources in the community. The social worker can also initiate projects based on the overall need of child headed families in order to support such children.

The social worker also needs to assist both children and their guardians to build relationships with each other. The social worker plays the role of an advocate as well as a broker. Payne (2005:295) refers to advocacy as representing the interest of the powerless to powerful individuals and social structures in order to improve their resources and opportunities. Berg-Weger (2010:281) refers to the role of a broker as linking clients to needed resources and services. The social worker may also perform case management duties as the social worker is able to identify various resources such as agencies with which he or she has made contact. For example, by referring a child for home-based care services, the child may benefit from various services like counselling, financial advice and medical advice.

5.4.3 Residential care

A third kind of alternative care is residential care. The Framework for Social Welfare Services (2013:29) refers to residential care as protection services that are rendered to children whose social functioning and quality of life is compromised by both social and environmental factors resulting in the child being placed in either alternative or residential care in order to meet the child's basic needs and enable optimal functioning. Weinberg (1983:1) refers to residential care or group homes as providing services such as physical care, psychological support, shelter and any required services rendered under the supervision of the carer. Muller and Steyn (1990:30) refer to residential care or group homes as alternative care for those children whose parental care is not conducive to meeting their basic needs. Kirst-Ashman (2013:301) confirms that the primary purpose is that residential care or group homes fulfil is to address more critical needs that cannot be provided by families.

Moses and Meintjes (2010:108) noted that there are two forms of residential care in South Africa; the one deals with the child in need of care and the other with the child who is in conflict with the law. For the purpose of this study, the focus was on the child of affected HIV households who are in need of care and protection. Furthermore, section 158(i) of the Children's Act No. 38 of 2005 recommends that the child be placed in a residential programme that will meet basic needs of the child such as medical, psychological or other treatment and

attendance needed is of relevance for children of HIV affected households who are in need of care.

Residential or group homes usually infer a single dwelling where a small group of children stays under the care of a couple or a trained housekeeper who is paid a salary. These group homes furthermore are ordinary houses situated in a residential area and inhabitants perform as a normal family (Muller & Steyn, 1990:30). Section 186(2) of the Children's Act No. 38 of 2005 recommends that a child be placed in alternative care until the child reaches 18 years of age. However, a study based on alternative care in the context of HIV and Aids conducted in the Western Cape reveals that six percent of children above 18 years continued to live in the facility following special arrangements between the social worker and the court (Moses & Meintjes, 2010:109). Kirst-Ashman (2013:302) noted that residential care or homes are offering more structured home environments to children in terms of consistent rules that help children to learn and develop more skills from one another or peer's children also receive individual children attention in order to effectively deal with each child's care and protection needs and build more intimate relationships with their peers and carers. It can be concluded that residential or group homes are effective in dealing with the emotional and psychological consequences of HIV and Aids and ideally focus on the individual child. It also allows a family environment for children with more or less the same care and protection requirements. However, these placements need to be terminated at the age of 18 years as these children need to be placed in the community for further support and care services with the assistance of the NGOs offering various programmes, reconstruction and after care services as recommended by ISDM (2006). These are discussed in the next section.

The role of the social worker in residential care is similar to the role of the social worker in foster care placements. The main role of the social worker is to assist in deciding whether the infected or affected child is ready to be on antiretroviral treatment; whether the carer is willing to assist in adherence issues, and to sort out disclosure issues with the infected child. The latter is done through counselling and education regarding Antiretroviral treatment, its consequences, side effects and the importance of adherence (Strug et al., 2002:10). The social worker furthermore assists the child individually or children in groups in dealing with the side effects experienced because of HIV and Aids; dealing with the loss of parents; behavioural and emotional feelings experienced through bereavement, and counselling and education (Kirst-Ashman 2013:301).

5.4.4 Adoption

A fourth kind of alternative care for children of HIV-affected households is adoption. A child is adopted when all parental responsibilities and rights of all persons related to the biological parent or parents are legally terminated and the child is placed in the care of another person who will legally have parental responsibilities and rights for the child (The Children's Act No. 38 of 2005: Sections 228 and 242). Besides a child support grant no grant is available for adoption (Abdool Karim & Abdool Karim, 2010:363). These authors further note that adoption of HIV and Aids-affected children is not considered often because of the stigma attached to HIV and Aids. Furthermore, adoption has not been part of African countries because the norm in the African culture is that the family members left behind when parents die it need to decide who is going to take care of the children (Grannis, 2011:13).

Kirst-Ashman (2013:303-304) explains that the role of the social worker in adoption is that of an advocate. This is because the social worker should be able to confirm that the adoption is in the best interest of the child after an evaluation of the social circumstances. Older children need to be helped through counselling to cope with grief and finally leaving his or her parents as well as adjusting to a new family. In addition, further support should be offered to adoption parents and families or groups to deal with emotional issues. Further linking these children or families to relevant groups or programmes in support of adoption parents is also needed. Thus, the social worker should render support services to adoptive parents and provide counselling to help them deal with the challenges of an adoption.

It is evident that in foster placement, child-headed households and adoption, almost all orphans and children made vulnerable by HIV and Aids are absorbed into extended families or in care where they have contact with their siblings and are financially supported by government in the form of social grants. There are those who are left with no options, however, as no family members or parents are left, or legal placements are applied for meeting their basic needs. These children are normally placed in residential care.

5.5 FOURTH LEVEL OF INTERVENTION: RECONSTRUCTION/ REUNIFICATION AND AFTER CARE

The fourth level of intervention recommended by the Integrated Service Delivery Model (2016:19) and the Framework for Social Welfare Services (2013:30) is reconstruction/reunification and after care. The ISDM (2016) and the FSWS (2013) recommend these social welfare services to be rendered after alternative care services so that the child is returned to his or her family or community and further support services which may be required to ascertain optimal social functioning and independency are offered. These services include community home-based care services and various programmes such as community-based care, drop-in centres, support programmes and home visiting. These services are discussed in the section below.

5.5.1 Community home-based care programmes

Community home-based care programmes are normally run by volunteer care givers affiliated to non-government organisations, community-based organisations and faith-based organisations (Uys & Cameron, 2003:6). Home-based care refers to any form of care given to ill people in their homes by formal and informal care givers. Both home- and community-based care assures a continuum of comprehensive health and community care services provided in homes and the community in order to assure that a person or family reaches an optimal level of comfort, social functioning and health (Van Dyk, 2012: 344).

One of the core functions of the Department of Social Development is to create an environment for empowering the poor and vulnerable through the support and promotion of community development work (Department of Social Development, 2010-2015:13). In the case of HIV and Aids, these services are usually provided by the family member or friend normally referred to as the primary care giver with the help of the community care worker, who is usually a trained person (Uys & Cameron, 2003:4). Ncama (2005:35) refers to care involving a family's friends who often are the primary care givers in informal home care giving. Hence, the Department of Social Development (2003:41) recommends that training for all care givers and health care workers is essential in order to ensure effective community-based care.

In South Africa, the South African Qualifications Authority (SAQA) Act 58 of 1995 thus created a framework for education and training of community care givers with specific

standards to promote and maintain a person's maximum level of comfort, functioning, health and a dignified death (Zerden, Zerden & Billinghurst, 2006:38).

These families and community care givers are usually supported by a multi-disciplinary team consisting of a medical doctor, a professional nurse, a social worker, a trained counsellor, a pastor or spiritual leader, volunteers, friends, neighbours, patients and communities that render a variety of services to the family who needs the service (WHO, 2001:43).

Of importance is that the focus of community home-based care can be on the person diagnosed with HIV and Aids, children, and the family care givers. In South Africa the following community home-based care programmes are identified by The Department of Social Development:

- Community-Based Multipurpose Centres and Child Care Forums that are linked to home community-based care services aiming to render a wide range of services to HIV-affected children and adults, such as providing meals, food gardens, child care, and bereavement counselling, voluntary counselling and testing services, assistance with applications for social grants, provision of home-based care and socialisation are also offered (Streak & Poggenpoel, 2005:32-33).
- Expanded works programmes aiming to create jobs for those who render home community-based care services to children and adults. The benefit of these programmes is that the carers are earning an income; obtain training and knowledge related to their jobs, which in return will assist in poverty relief; expanding their knowledge of other areas of employment; and obtaining overall skills development (Streak & Poggenpoel, 2005:3).

5.5.2 Drop-in centres and support programmes

Drop-in centres normally consist of a single facility where HIV counselling and education services can be accessed. These centres usually also offer meals for children, advice on homework, and a safe place for fun activities after school and, possibly, on weekends and during school holidays; as well as support group activities (Grannis, 2011:133). The latter provide children with educational stimulation, a nutritious diet and safety, as well as keeping them away from negative activities.

Support groups focus on psychosocial counselling. The support group programme is normally combined with activities that are directed towards income generation (Uys & Cameron, 2003:82). These activities can include making beaded ribbons, paper bowels, hats from plastic bags, table cloths, gardening, chicken farming and making foodstuffs.

Support groups furthermore are directed at empowerment, which results in self-confidence, to assist people in coping with their diagnoses and in social networking. These can result in outside-the-group contact and assistance, where needed, and future planning discussions related to future placement of and arrangements for their children and identifying a provisional carer (Russel & Schneider, 2000:25). In addition, support groups can ensure safety, confidentiality, non-discrimination, information and respect for the member's HIV status and are normally initiated by professional persons like psychologists, social workers, or nurses (Uys & Cameron, 2003:82).

5.5.3 Home visiting services

Similar to community home based care, the patient is visited by home based carers at home and they can offer education to the patient and his or her family about how to provide for their basic care needs (Uys & Cameron, 2003:118). The carer can provide support with house cleaning, cooking, accompanying patients to health centres, fetching their medication, helping with errands, arranging for food parcels and to provide for other material needs (Russel & Schneider, 2000:331).

The latter activities are individual or community based and of an informal nature. However, integrated home-based care services are needed to render effective services to HIV affected households. The services should engage all other service providers such as community care givers, clinics, hospitals, NGOs, support groups and community-based organisations (Uys & Cameron, 2003:6). The aim of integrating these different service providers is to coordinate outcomes in primary, secondary and tertiary prevention intervention (WHO, 2004:5). Hence comprehensive intervention is needed, as explained below:

- Comprehensive home-based care services are provided in addition to the above services. These programmes can entail nursing care, clinical management, psycho-spiritual support and social support (WHO, 2004:7). These services include the following activities: educating family members about wound care, provision of nutrition, administration of medication, and monitoring TB medication. In addition, educating

family members with regard to how to care for sick relatives, providing counselling, providing support and supplying material needs can be offered (Russel & Schneider, 2000:20-23). Russel and Schneider (2000:20-23) refer to various organisations in the Western Cape, such as the Red Cross, St Luke's Hospice, the Child Health Unit at the University of Cape Town and Nazareth House as organisations that played a major role in rendering a comprehensive package of services to families in different areas in focusing on different services for intervention in order to meet the needs of these families. Furthermore, training for home-based care is provided by both St Luke's Hospice and the Red Cross.

These services are rendered after discharge from the hospital or health centre. The social worker's role is to act as a broker and it is usually started by the social worker in the hospital in collaboration with the social worker in the community. The social worker's role as a broker is to link the client or family with the needed resources in the community and render follow-up services in order to ascertain whether the needed resources are obtained. The latter also requires that the social worker knows her resources or gains knowledge about relevant resources. Hence Berg-Weger (2010:281) mentions that the social worker should be able to network, to form coalitions, and partnerships with organisations and communities, as a broker. In addition, the social worker should be able to negotiate for services that are not available through advocacy. Berg-Weger (2010:281) refers to advocacy as presenting the needs of a group to those who are in authority locally, on a country level or nationally.

The social worker also plays a crucial role in initiating support groups for HIV and Aids-affected children and adults in order to deal with challenges such as disclosure issues, adherence issues in children, skills development, supporting one another and empowerment. These groups are normally initiated after mutual needs assessment by a social worker and the community. The social worker will normally act as a facilitator and an educator developing an agenda with the group members, and then evaluate how the sessions provide for their needs based on the daily or weekly activities. Kirst-Ashman (2013:110) explains the social worker's role as facilitator as guiding a group for a variety of purposes. Berg-Weger (2010:281) noted that social work administration activities, which are also needed, entail overseeing programme development, doing fund raising, budgeting for and supervising those who deliver the services. Reconstruction and after-care services are continuing care and support services

provided by both governmental and non-governmental organisations to HIV and Aids-affected households at home or in the community after an HIV diagnosis or discharge from hospital. These services allow the households an opportunity to develop adequate skills and knowledge about how to care for their families, as well as creating a supportive environment amongst those affected and the carers.

5.6 CONCLUSION

This chapter presented policies and legislation implemented by the South African government in order to respond to the consequences of HIV and Aids for affected households. The discussion of the role and responsibilities of social workers with regard to prevention and early intervention, statutory, alternative care and integration, and after care of affected HIV and Aids households clearly indicates that intervention on all levels of the ISDM (2006) is crucial in order to deal effectively with the consequences. Moreover, the ecological perspective is essential in guiding social work intervention when dealing with the consequences of HIV and Aids among affected children and households in order to enhance and sustain a desired level of functioning of these households through meeting their welfare needs.

In sum, non-governmental organisations can play a tremendous role in dealing with the consequences of HIV and Aids for affected households.

CHAPTER 6:

SITUATIONAL ANALYSIS OF SOCIAL WORK SERVICES OFFERED BY NON-GOVERNMENT ORGANISATIONS TO HOUSEHOLDS AFFECTED BY HIV AND AIDS

6.1 INTRODUCTION

In this chapter, the findings of this study are set out in three sections. This is done to execute objective four of the study, which was to investigate the nature and extent of social work services rendered by social workers in NGOs to households affected by HIV and Aids in the Cape Metropole. Section A provides a profile of the participants regarding their qualifications, training related to HIV and Aids, work experience and experience working in the field of HIV and AIDS. Section B presents the mission of the organisation, sources of funding of the NGO, utilisation of funding and its client base. Section C presents findings concerning the consequences of HIV and Aids and the utilisation of policies and legislation related to households affected by HIV and Aids. Finally, section D presents social work services rendered by NGOs to HIV and Aids-affected children and households from an ecological perspective and in terms of the ISDM (2006) and the Framework for Social Welfare Services (2013).

6.2 SECTION A: PROFILE OF PARTICIPANTS

The participants were requested to provide information about their highest qualifications, specialised training related to HIV and Aids, years of experience as a registered social worker, years of working in the field of HIV and Aids and in what professional capacity they are involved in HIV and Aids welfare activities. This information from the participants allowed creating a profile for the participants eligible for the study.

6.2.1 Qualifications

The participants' highest qualifications were explored because this could give an indication of how competent and confident, they are in practising their roles as social workers. The findings are presented in Table 6.1.

Table 6.1: Qualifications

Qualifications	f
Diploma Social Work	01
BA Social Work	11
BA Honours Social Work	06
MA Social Work	03
PhD Social Work	00
Total	21

N = 21

Table 6.1 indicates that 11 (52.4%) of the 21 participants qualified with a B degree in Social Work, while six (28.6%) had an Honours degree in Social Work, followed by three (14.3%) who possessed a Master's degree in Social Work and one (4.8%) obtained a Diploma in Social Work.

Just more than half of the participants (11, or 52.4%) therefore obtained a BA Social Work degree while one (4.8%) obtained a Diploma in Social Work. The rest (9, or 42.8%) presented post-graduate qualifications in Social Work. Thus all the participants were qualified in Social Work, which was a criterion for inclusion in the study.

6.2.2 Training related to HIV and Aids

The participants indicated other qualifications or specialised training related to HIV and Aids that they had obtained. This was of importance as it determined additional skills and knowledge acquired in order to render services to HIV and Aids-affected households. The findings are presented in the Table 6.2.

Table 6.2: Training related to HIV and Aids

Training	f
HIV counselling and testing	09
HIV counselling and care	04
Adherence counselling	02
None	06
Total	21

N = 21

As shown in Table 6.2, nine participants (42.9%) had training in HIV counselling and testing; four (19%) had training in HIV counselling and care; two (9.5%) had training in adherence counselling and six (28.6%) indicated that they had no training related to HIV and Aids.

The findings indicate that most (15, or 71.4%) of the participants had received training related to HIV and AIDS which equipped them to work in the field of HIV and Aids.

It should also be noted that HIV Counselling and Testing, HIV Counselling and Care and Adherence Counselling are interrelated training activities aiming to enable social workers to execute prevention and care services. South Africa's Child Care and Protection Policy (2017:157) noted that the rendering of care and protection services require well qualified professionals such as social workers.

6.2.3 Work experience

The years of experience of participants as a registered social worker are presented in the Table 6.3.

Table 6.3: Work experience

Years	f
01-03	12
04-06	06
25+	03
Total	21

N = 21

The results indicate that just more than half (12, or 57.1%) of the participants had between one and three years of work experience, six (28.6%) had between four and six years, followed by three (14.3%) with more than 25 years of work experience. The results indicate that all the participants practicing as registered social workers in this respect met another criterion for inclusion in the study.

6.2.4 Participants' experience of working in the field of HIV and Aids

The experiences of participants working in the field of HIV and Aids are presented in Table 6.4.

Table 6.4: Experiences of participants working in the field of HIV and Aids

Years	f
01-03	12
04-06	05
22-24	01
25+	03
Total	21

N = 21

As shown in Table 6.4, just more than half (12, or 57.1%) of the participants had less than four years' experience in working in the field of HIV and AIDS; five (23.8 %) had less than seven years; one (4.8 %) had under 25 years and three (14.3%) had more than 25 years' experience working in the field of HIV and Aids. It is therefore evident that the participants met another criterion for inclusion in the study, which was that they had to have at least one year of experience in working in the field of HIV and AIDS.

6.2.5 Registration of Organisations

The findings indicate that all (21 or 100%) participants were employed by organisations that are registered as NGOs in terms of the Act on NPOs (Act 71/1997, but not registered as designated child protection organisation in terms of the Children's Act No. 38 of 2005. This was another criterion for inclusion in the study.

6.3 SECTION B: THEMES REFLECTING PROFILES OF NGOS

This section reports on the profile of the NGOs. Two themes related to the profile of the NGOs and sub-themes were identified under these themes:

6.3.1 Theme 1: Mission of Non-Profit Organisations

The first theme related to the profile of the organisations concerning the mission of the NGOs.

The sub-themes related to the mission of NGOs are discussed below.

6.3.1.1 Sub-theme 1: Networking

Most of the participants indicated that the mission of their organisation concerned net-working, as illustrated in the narratives below:

> "To promote and technically support city wide and nationwide **community networking** and provide access to social services, health services and care for the most vulnerable." (Participant 13)

> "It is basically for role players in the community to **collaborate** to meet the needs of the children and families." (Participant 12)

These findings are in line with the ISDM (2006) and the Framework for Social Welfare (2013:9) that focuses on equality, collaboration and integrated service delivery in order to meet the needs of communities at all levels of human functioning. These two policies recommend that welfare services such as prevention, early intervention, statutory/residential/alternative care and reunification and after care should be rendered at a continuous level. In doing so, the optimal functioning of the community will be achieved by NGOs through collaboration and networking by role players in order to meet the needs of the HIV and Aids-affected households.

6.3.1.2 Sub-theme 2: Poverty alleviation

Studies reveal that the majority of women and children with HIV and Aids are living in extreme poverty (Foster et al., 2005:93). Accordingly, the findings below demonstrate that the mission of most NPOs is focused on poverty alleviation.

> "The mission of the organisation is to flourish the … area, **root out poverty** as far as we develop the … area." (Participant 5)

> "We are striving to change the lives of the vulnerable and orphaned people who are living in **poverty**." (Participant 16)

These findings are consistent with the White Paper for Social Welfare (1997:140-143) that promotes poverty alleviation and The White Paper on Families in South Africa (2012:39-43) that recommends promoting healthy family life through providing for the basic needs of families and their children, encourages empowerment and strengthening of the family through social assistance and social security made available through the Social Assistance Act No. 13 of 2004.

6.3.1.3 Sub-theme 3: Empowerment

With HIV and Aids-affected households there is a need for NGOs to offer a variety of social services to the infected as well as to their families in order to enable them to function independently. Some participants revealed that the mission of their organisations concerned:

> "To **empower the vulnerable people** from the community by giving them skills and counselling so that they can be able to stand on their own and be able to support their families." (Participant 19)
>
> "At the organisation we uplift and **empower communities** for the betterment of their lives." (Participant 20)

These findings are consistent with the White Paper for Social Welfare (1997:140-143) which promotes poverty alleviation and the White Paper on Families in South Africa (2012: 39-43) which recommends promoting healthy family life through providing for the basic needs of families and their children, encourage empowerment and strengthening the family through social assistance and social security made available through the Social Assistance Act No. 13 of 2004.

In addition, family preservation focusing on family safety through prevention and intervention to minimise child abuse, neglect, HIV and Aids, poverty, child and parent or parents' mortality in order to alleviate family disintegration that results in child-headed households and to rather promote family reunification is also emphasised in this policy document.

The findings related to the mission statements of NGOs reveal that, for families affected by HIV and Aids to be able to function at a desired level, NGOs need to network with other role players to eliminate the spread of HIV, alleviate poverty and empower families to improve the quality of their lives.

6.3.2 Theme 2: Sources of funding of NGOs

NGOs need funding to sustain the organisations' functioning, as well as to accomplish their mission.

The participants explained where they obtain their funding for service rendering to clients. Table 6.6 presents the sub-themes that emerged.

Table 6.6: Sources of funding of NGOs

THEME: SOURCES OF FUNDING	
SUB-THEMES	**NARRATIVES**
Subsidy from state departments	"We are funded by the **Department of Social Development** and the **Department of Education**." (Participant 4) "It gets its funding from **Department of Social Development** from the **Department of Health** and we also get funds from the **Department of Education** because we have an early child development." (Participant 5) "It gets its funding from the **Department of Social Development** and because also we are working with health issues such as HIV and AIDS, we also get funding from the **Department of Health**." (Participant 2)
Lottery	"We got funding from **Lotto**." (Participant 6) "We are funded by **Lotto**." (Participant 5)
Corporate sectors	"For this programme currently, we are funded by **Foschini** and **Truworths** like they give us clothes." (Participant 7) "We receive funds from various supporters like individual or family sponsors and **businesses**." (Participant 10)
Foreign Funders	**Overseas sponsors** like Germany, Austria, UK and Switzerland we call them friends of home from home." (Participant 9) "The other donors that come from **overseas** like Norway and Robotic fund our computer studies."(Participant 4)

6.3.2.1 Sub-theme 1: Subsidy from state departments

The findings indicate that sources of funding include subsidies received from the Department of Health, Department of Social Development and the Department of Education.

This finding corresponds with Non-Profit Organisation Act No. 71 of 1997 in terms of which NGOs are registered and qualify for subsidies.

6.3.2.2 Sub-theme 2: Lottery

NGOs also get funding from the **Lotto** in terms of the Lotteries Act No. 57 of 1997 which explains that they are eligible to apply for funding from the National Lotteries Commission (http://w.w.w.nlcsa.org.za/what-organisations-arefunded/).

6.3.2.3 Sub -theme 3: Corporate sectors

As can be seen, **corporate sectors** like **Truworths, Foschini** and, individual and family businesses also provide funding to NGOs. It seems that the corporate sector offers funds to

NGOs that render services in communities and that they intend to improve the quality of life of people through charity in various ways such as cash donations, sponsorships, cause-related marketing and charity services (https://grantspace.org/resources/knowledge-base/corporate-giving/).

6.3.2.4 Sub-theme 4: Foreign funders

NGOs also receive funding from **foreign funders**. Foreign funders like USAIDS offer global funding aimed at alleviating poverty through various programmes such as food assistance programmes, and saving lives in terms of reducing infant, child and maternal morbidity and mortality (https://www.gov/globalgoals). The latter funder's vision is directly related to the welfare services offered by NGOs to HIV and Aids-affected households in South Africa.

The findings reveal that NGOs are dependent on funding from various sources ranging from government subsidies to funding from local and overseas donors.

6.3.3 Theme 3: Utilisation of funding for services

NGOs need funding to render Social Work services to households affected by HIV and Aids. The participants were asked to tell how the organisation utilised the funding it receives to meet the mission of the organisation and to address the needs of HIV and Aids-affected households. The following sub-themes and related categories emerged.

6.3.3.1 Sub-theme 1: Poverty alleviation

The first sub-theme identified from most responses was that funds were utilized for poverty alleviation, which is a focus of the mission of some NGOs. The two categories that emerged are discussed next.

6.3.3.1.1 Category 1: Food and clothing

In order to alleviate poverty, basic human needs need to be attended to for the benefit of the entire family. Hence, section 28 1c of the Bill of Rights of The Constitution of the Republic of South Africa (1996) protects families and infected and affected children and guarantees them the right to housing, food, medical services, social security and welfare services. The utilisation of funding for poverty alleviation by NGOs is evident from the following narratives:

> "We use the Department of Social Development subsidy for **food**." (Participant 6)

> "We use the money of the donors for **school uniforms**, **long pants**, **jackets** and also **winter stockings** and **clothes**." (Participant 4)
>
> "We use the donations from Truworths which are **clothes** that were recycled and give to the HIV positive women at the sewing project and to the needy." (Participant 7)

These findings reiterate the White Paper for Social Welfare (1997) which emphasises poverty alleviation.

6.3.3.1.2 Category 2: Practical assistance

When discussing how the organisation utilised funding, some participants referred to the use of funds to offer practical assistance to households affected by HIV and Aids. They said:

> "NACOSA gives us funding for **transport for the foster mothers** to attend the training." (Participant 14)
>
> "NACOSA also give us money for **transport for beneficiaries** who are coming from far away for our services like to attend the adherence groups." (Participant 6)
>
> "We buy **electricity** for the child headed households." (Participant 2)

These findings reflect the focus of both The Constitution of the Republic of South Africa (1996) and the White Paper for Social Welfare (1997) that explain how the rights and welfare of children and families should be respected and how their basic needs should be met.

6.3.3.2 Sub-theme 2: Empowerment

The second sub-theme identified by the majority of the participants is that funds are utilised for empowerment, which is another focus of the mission of some NGOs. Empowerment is aimed at uplifting individuals in order to enable them to function independently (Page & Czuba, 1999:1). Many participants indicated that empowerment can be achieved through the programmes and residential care they offer. The two categories which present this sub-theme are discussed below.

6.3.3.2.1 Category 1: Intervention services

Group work is a method of social work intervention that is often used for empowerment of service users. According to Russel and Schneider (2000:25), support groups are directed at

empowerment of their members, which results in improved self-confidence; to assist people in coping with their diagnoses; and in social networking. This use of groups for empowerment is corroborated by one participant who said:

> "Since it is a requirement of the Department of Social Development to offer psychosocial **groups** for children and adults, we use the subsidy to offer intervention programmes for empowerment of HIV and Aids affected families." (Participant 17)

6.3.3.2.2 Category 2: Residential care

Protection services that provide shelter are often needed by members of HIV and Aids-affected households. The Framework for Social Services (2013:29) refers to residential care as a protection service that is rendered to children whose social functioning and quality of life are compromised by both social and environmental factors resulting in the child being placed in either alternative or residential care in order to meet their basic needs and to be able to function optimally. The latter is confirmed by the Children's Act No. 38 of 2005 sections 150(1) and (2) that refer to a child in need of care and protection as a child with no visible support. The utilisation of funding to meet this requirement is evident from the following narratives of participants:

> "An overseas donor started this organisation because of HIV and Aids because they see the households are affected around … then they built the **shelter for children and women**." (Participant 21)

> "The funding is mainly used for the maintenance of the **Child and Youth Care Centre** and the **homes that the children are living in**." (Participant 4)

These findings are supported by The Constitution of the Republic of South Africa (1996) and the White Paper for Social Welfare (1997) that emphasise empowerment through meeting the basic needs of both children and families and offering protection and care services.

Furthermore, it is worth noting that the Mid-year Population Report (2014:1) confirms that shelter is a basic need for women and children. In South Africa, women and children are the most severely impacted by the HIV and Aids epidemic and they often are in need of shelter.

The findings reveal that NGOs utilise the funding they receive to fulfil the mission of their organisations.

6.3.4 Theme 4: Client base of NGOs

The study focused on services rendered by NGOs to HIV and Aids-affected households. The following four sub-themes emerged from the interviews which explored the client base of the NGOs. These sub-themes are discussed here. The findings are contained in Table 6.6.

Table 6.6: Client base of NGOs

THEME: CLIENT BASE OF NGOs	
SUB-THEME	**NARRATIVES**
Orphans	"We are working with children between the age of 0 to 18 years both boys and girls, they are **orphaned** meaning that some of their parents are deceased due to HIV and AIDS like they now become affected or infected or both." (Participant 3)
Women	"I am coordinating and managing this programme of HIV positive **women** from 18 to 49 years." (Participant 7)
Extended family members	"We work with **grannies** and **aunts**." (Participant 6) "We find that most of these children are left with **grannies** or **aunts**." (Participant 6)
Child-headed households	"And as I have mentioned that the organisation has expanded its services because now we are also having **Child headed households** for which we provide more or less the same services." (Participant 2)

6.3.4.1 Sub-theme 1: Orphaned children

The first sub-theme revealed by some participants was that they are working with all children below 18 years. They render services to both boys and girls who are **orphaned**, meaning that one or both parents are deceased due to HIV and Aids. Therefore, these children **are affected or infected or both**. The finding is an indication that these orphaned children are in need of care and protection as is stipulated in section 150(1) and (2) of the Children's Act No. 28 of 2005, which refers to a child in need of care and protection as a child who has been abandoned or orphaned and has no visible means of support are of relevance.

6.3.4.2 Sub-theme 2: Women

The second sub-theme refers to women as part of the NGO client base. Most of the participants indicated that they are rendering services to HIV positive **women** between 18 and 49 years.

This finding is in keeping with the Mid-year Population Estimates (2015:6-7) that report that South Africa remains one of the countries most affected by the HIV and Aids epidemic, with women of productive and parenting age being the most affected.

Furthermore, the abovementioned age group is the most economically productive age group and due to being HIV infected or affected they may either die at an early age (Thurlow et al., 2009:4). Consequently, these women may leave their children behind to be cared for by those family members left behind.

6.3.4.3 Sub-theme 3: Extended family members

The third sub-theme that was identified concerned extended family members who were part of the client base of NGOs. It was documented that the loss of a parent can have serious consequences for an affected child due to lack of provision for basic needs, such as food, shelter, clothing, health care and education (Abdool Karim & Abdool Karim, 2010:374). Hence, extended family members can move in and out of households or move from different destinations in order to assist with the care of those left behind as the result of the death of a family member. The responsibility of caring for these children is normally shifted to extended family members. Participant responses confirm that:

> "Most of these children are left with **grannies** and **aunts**." (Participant 5)

> "We find that most of these children are left with grannies or aunts." (Participant 6)

6.3.4.4 Sub-theme 4: Child-headed households

The fourth sub-theme shows that child-headed households are included in the NGO client base. Pharoah (2004:3) refers to an affected child-headed household as a household where the parent, guardian or carer of the household is terminally ill, has died or has abandoned the children.

One participant explained that child-headed households come to be included in the client base of the NGO:

> "We are also having **child headed households** for which we provide more or less the same services." (Participant 2)

6.4 SECTION C: THEMES RELATED TO NEEDS OF HOUSEHOLDS AFFECTED BY HIV AND AIDS AND SERVICES PROVIDED BY NGOS

The consequences of HIV and Aids imposed on both HIV and Aids-affected households are severe. Children born from HIV-positive mothers are vulnerable to abandonment by their mothers due to a variety of issues such as parental fear of being unable to care for the child, being a single parent, illegitimate births, fear of family break up, poverty, amongst others. Furthermore, in many cases a diagnosis of HIV may mean that the household will dissolve, as parents die and children are sent to immediate families or relatives for care (Abdool Karim & Abdool Karim, 2010:373).

6.4.1 Theme 5: Consequences of HIV and Aids

It became evident from the views of many participants that HIV and Aids-affected households to which they render services experience various consequences of HIV and Aids as discussed in Chapter 2. The six sub-themes that were explored within the theme of consequences of HIV and Aids, as well as the corresponding categories, are discussed in the sections below.

6.4.1.1 Sub-theme 1: Survival and care needs

Analysis of transcripts revealed that the loss of a parent can have serious consequences for an affected child due to lack of provision for basic needs such as food, shelter, clothing, health care and education (Abdool & Abdool Karim, 2010:374). The four categories related to this sub-theme are:

6.4.1.1.1 Category 1: Basic needs

Of importance for this study is that section 28(c) of the Bill of Rights in the Constitution of South Africa 1996 guarantees the right to housing, food, medical care services, social security and welfare for all children. In this regard, Gow and Desmond (2002:10) state that supporting social security and social relief for HIV and Aids-affected households requires support in the form of food and finances which they normally are in need of, is of paramount importance for these household's survival.

An analysis of the narratives of participants revealed that the survival needs of most families are related to **basic needs** that are not met, as revealed in the narratives below:

> "The children need **shelter;** they need **food** and **clothes** as I said their parents died due to HIV and AIDS." (Participant 4)
>
> "After the mothers are tested positive they need money for **food a**nd **money** for the children to go to school." (Participant 15)
>
> "As I mentioned these families are in need of **shelter**, **food** and **education**." (Participant 16)
>
> "The mother passed away, there is **no food** or even **birth certificates, t**hey are just struggling there is **no food** or **clothes**." (Participant 19)

The findings reflect how unmet basic needs lead to the poverty experienced by HIV and Aids-affected households and emphasise the challenge for NPOs to address poverty, as stated in their mission statements and required by the White Paper for Social Welfare (1997) and the White Paper on Families in South Africa (2012).

6.4.1.1.2 Category 2: Shifting responsibility of caring for children to extended family members

A category of meaning that arose with regard to the sub-theme survival and care needs has been that of the responsibility of caring for children normally which is shifted to the extended family. As stated previously, extended family members can move in and out of HIV-affected households or move from different destinations in order to assist with the care of those left behind after the death of a member. Consequently, the responsibility for caring for the children is normally laid on members of the extended family (Richter et al., 2004:12). The narratives of participants reveal that due to ill health or death the responsibility of caring for the children are left with various family members as can be seen in the narratives below:

> "I think only 20% of the children have mothers otherwise they stay with **grandmothers**, **other children** with **foster parents**." (Participant 6)
>
> "We went out and find out that most of these children are left with **grannies** and **aunts**." (Participant 5)

The findings confirm that next of kin usually take responsibility of caring for family members (Richter et al., 2004:12). The need of next of kin for support services should be noted by NPOs.

6.4.1.1.3 Category 3: Children taking responsibility for care of siblings

As mentioned previously, prevalent experiences mentioned by some participants is that children have to take responsibility for caring for other siblings. Research has shown that children in households affected by HIV and Aids often take responsibility for the house chores, care of the other siblings and caring for the remaining, often dying, parent (Abdool Karim & Abdool Karim, 2010:375; Patenaude et al., 2008:20). This can be seen from the following narrative:

> "You will find that this child is a child who still needs to be taken care of and she or he has to **take care** of **these siblings,** this innocent child becomes deprived in many ways and in her psychological development." (Participant 2)

It is evident that children in the affected households, in addition to depending on extended family, are often involved in caring for siblings (Pharoah, 2004:3). Consequently, child-headed households are included in the client base of NGOs, as was reported earlier in this chapter.

6.4.1.1.4 Category 4: Victims of exploitation and abuse

A problem that became clear from the findings is that child-headed households are often prone to becoming victims of exploitation and abuse. Singhal et al. (2003:74) warn that children in child-headed household are prone to becoming involved with prostitution in order to have more money, and may end up living on the streets due to limited income and food. The following narratives describe some participants' experience of the consequences of HIV and Aids:

> "The children become **infected** as they **got sexually active** with older people who provide them with money." (Participant 2)
>
> "These children, the majority of them, have been **victims of sexual abuse** for the purpose of survival and needs to be taken care of." (Participant 1)
>
> "The children become **infected** due to **prostitution** in order for them to generate income." (Participant 2)

From the above findings it is evident that in terms of the Children's Act no 38 of 2005 section 110(1) these children are in need of protection services rendered by some NGOs that are registered as designated child protection organisations in terms of the Children's Act 38 of 2005.

6.4.1.2 Sub-theme 2: Emotional needs of children

The second sub-theme reported on by the majority of the participants refers to the emotional needs of children in HIV and Aids-affected households.

6.4.1.2.1 Category 1: Emotional stress of losing a parent or care giver

Emerging from the experiences of the participants with regard to the emotional needs of children is that of emotional stress experienced by children after losing a parent or care giver. It has been observed that the effects of HIV and Aids on children are physical, emotional and psychological, as well as socio-economical. These all begin while children still live with their parents and see their parents becoming ill, deteriorating and are eventually dying (Deacon & Stephrey, 2007:1). However, children are affected differently depending on their ages, also with regard to how they suffer from emotional stress and the fear of losing a parent or a care giver. The following narratives from participants reveal how children are affected by emotional stress and trauma related to the death of their parents and family members:

> "The children cannot **cope with** their **parent's death** and are not even aware of the causes of **death**." (Participant 14)
>
> "These children also went through **trauma**." (Participant 3)
>
> "These children who are HIV positive and when we do counselling they will cry and **worry about dying**." (Participant 9)
>
> "They **fear** that the next person granny or aunt will also **die**." (Participant 12)

Experiences related to death generate fear in children exposed to such experiences. This is coupled with anxiety and grief as they begin to imagine a future without a parent and having to depend on other family members and siblings for support (Foster et al., 2005:186) as is explained by some participants:

> "They will cry and worry about **dying**." (Participant 16)
>
> "They fear that the next person or granny or aunt will **also die**." (Participant 12)

These findings are clear indications that these children require counselling that can be offered by NGOs.

6.4.1.3 Sub-theme 3: Health care needs

The third sub-theme of health care needs as a consequence of HIV and Aids arose from recurring references to suffering of children and families due to illness and death.

6.4.1.3.1 Category 1: Sickness and ill health

The first category that emerged from this sub-theme was that of sickness and ill-health. The progression of HIV to Aids in the absence of ART is indefinite as a person may develop Aids within months or weeks following diagnosis and may require medical attention at local clinics and hospitals due to opportunistic infections that may put heavy pressure on both the health system and health care worker (Stine, 2012:157; Abdool Karim & Abdool Karim, 2010:71). This is evident from the following narratives:

> "The community worker will report that the **mother is sick** and that they did not take **their medication**." (Participant 14)

> "As I said this **illness** can have a huge impact on the child and the sick person as it can also cause stress." (Participant 12)

In this regard it is worth noting that both the ISDM (2006) and the Framework for Social Welfare (2013) recommend collaboration between NGOs and integrated service delivery by them in order to meet the needs of HIV and Aids-affected households at all levels of their functioning as human beings.

6.4.1.3.2 Category 2: Stigma

Another category that emerged under the sub-theme health care needs is that of stigma. Foster et al. (2004:156) asserted that stigma and discrimination are the most powerful forces that inhibit every effort to combat HIV, as it prohibits people from accessing treatment. This is illustrated by the following participant narratives:

> "There is a huge **stigma** around HIV and AIDS and infected families are not going to the clinic because they fear the stigma." (Participant 8)

> "Because, you know our health facilities are not friendly to our HIV women they are still putting **stigma** to the people like they still got different folders, cards and are treated in different rooms at clinics." (Participant 7)

These are significant findings that reveal that stigma and discrimination have been associated with HIV and Aids since the very onset of the epidemic and is a challenge to households affected by HIV and Aids. It can even get worse as the child grows older (Save the Children, 2001:1). It also points to the need for counselling by social workers at NGOs in HIV-affected households.

6.4.1.4 Sub-theme 4: Educational needs

The fourth sub-theme identifies the recurring notion of the consequences of sickness and ill health of children's educational needs, as is evident from the category below.

6.4.1.4.1 Category 1: Missing out on school

Despite the fact that the children of HIV-affected households are of school-going age, their attendance is often hindered by various responsibilities like caring for ill family members and lack of finances, as mentioned earlier. These children are most probably attending primary, secondary or tertiary school and will be exposed to a variety of challenges that may result in temporary or permanent missing out of school. The following statement is one participant's description of this situation:

> "Some of the children's parents are very sick, there is no money, no food and then they just do **not go to school**." (Participant 21)

This finding corresponds with findings by Foster et al. (2004:138) who confirm that school attendance of children from HIV-affected households is often very poor due to lack of income to cover the child's schooling needs. Booysen (2009:58) furthermore noted that it is often expected of the child to leave school to provide care or to make a financial contribution to the declining household income, as is evident from the following narratives:

> "They are not even having grade 8 then **drop out** very early due to their parent's death and not having **money** or other families to support them." (Participant 13)

> "Because they **care for their mothers,** they will cook for them, make sure that they get their medication before going to school and are sometimes late or need to go with the mother to the clinic and might not go to school." (Participant 12)

It is evident that the educational needs of children affected by HIV and Aids are not always fully met due to role changes and responsibilities that they need to take. Therefore, these children need to be protected and supported by services rendered by NGOs.

6.4.1.5 Sub-theme 5: Economic position

The fifth sub-theme shows how the consequences of HIV and Aids affect the economic position of HIV and Aids-affected households that results in the survival and care needs of these households not being fully met due to unemployment and ill health as portrayed in Category 2, below.

6.4.1.5.1 Category 2: Unemployment

A prominent challenge identified by many participants has been that of unemployment due to ill health. It is worth noting that the HIV epidemic in South Africa mostly affects the working age group of the population. Statistics South Africa indicates that the majority of instances of HIV infection or death among both men and women occur at the age of 25 to 35 years (UNAIDS, 2013:1). In addition, the prevalence of HIV is higher amongst the disadvantaged who are unemployed; the most impoverished persons with low skills and income (Daniel et al., 2010:307). The following excerpts are cited in this regard:

> "As indicated, these are poor families with **little** or **no income,** their only income is normally the grants they receive." (Participant 19)

> "There is a stage now where they **cannot go to work,** I mean it affects the family financially more especially where there is no other family to assist and it is only the mother and the child." (Participant 12)

The consequences of HIV for affected households are that, where there is no income or little income, households often tend to be unable to afford a nutritious diet. This is confirmed by Rohleder et al. (2009:207) who noted that food consumption may drop and may affect households in that families become malnourished, which may lead to the rapid progression of HIV and Aids. One participant's narrative illustrates this:

> "They are actually **getting sick** because there is no support or care." (Participant 5)

The findings show that HIV-affected households often are unable to meet the basic needs of their children due to lack of income and ill health. Hence Streak et al. (2005:3) recommend that

community home-based care services including providing meals, food gardens, assistance in applying for grants and the provision of home-based care services are essential for meeting the needs of HIV-affected households. These findings should be taken into consideration by NGOs when they are planning services for affected families.

6.4.1.6 Sub-theme 6: Welfare needs

The last sub-theme refers to welfare needs that arose as another one of the profound consequences of HIV and Aids for affected households, as portrayed in the next category.

6.4.1.6.1 Category 3: Need for care and support services outside the family system

Participants indicated that the consequences of HIV and Aids experienced by affected households classify them as being in need of care and support from various stakeholders because their families often are not able to care for themselves. According to Taylor-Brown and White-Gray (1996:61), HIV and Aids-affected households make demands on both extended families and communities because their needs can often not be met by an institution such as the hospital alone.

Statutory, residential and alternative care mandated the ISDM (2006) and the Framework for Social Welfare Services (FSWS) (2013) therefore are often required to care for children of HIV-affected families because they can be regarded as children in need of care. In addition, the ISDM (2016) and the FSWS (2013) recommend social welfare services to be rendered so that children who are removed from their families may be returned to their families or communities and to offer further support services which may be required to facilitate optimal social functioning and independency. These services include community home-based care services and various programmes such as community-based care, drop-in centres, support programmes and home visiting. The following narratives reflect this:

> "These children and their parents or siblings are sometimes very sick and then need to be placed here at the **respite care** unit." (Participant 2)
>
> "The adults normally default their TB treatment and Antiretroviral treatment, so we also admit them to respite care for the recovery process." (Participant 4)
>
> "Our homebased carers are also working in the communities where they **monitor the** HIV infected families' **treatment,** assist with **educating the family** about HIV

and TB and offer **support services** like collecting medication and bathing them." (Participant 4)

The findings related to the consequences of HIV and Aids for affected households reveal that these consequences are severe and that these households need various services that can be offered by NGOs.

6.5 FAMILIARITY WITH POLICIES AND LEGISLATION RELATED TO HIV AND AIDS

For NGOs to respond to the needs of HIV and Aids-affected households they need to be familiar with policies and legislation that can guide their services. The Table 6.7 lists the policies and legislation with which the participants were familiar.

Table 6.7: Familiarity with policies and legislation related to HIV and Aids

Policies	**f**
The Constitution of the Republic of South Africa	10
White Paper for Social Welfare	03
White Paper on Families in South Africa	0 7
Integrated Service Delivery Model	04
Frame Work for Social Welfare Services	02
The HIV and AIDS and STI Strategic Plan for South Africa	14
Children's Act 38 of 2005 and Amended Act 41 of 2007	21
Social Assistance Act 2004	19

N = 21

The findings presented in the table are discussed below.

6.5.1 Children's Act No. 38 of 2005

All (21, or 100%) of the participants indicated that they are familiar with the **Children's Act No. 38 of 2005** and the **Amended Act 41 of 2007**. This finding echoes the views of Budlender et al. (2008:21), who refer to the Children's Act as a legal document aiming to protect and prevent children from physical, emotional and mental abuse, as well as giving the parents, care givers and legal guardians the same responsibility to protect, support and care for the child with

specific focus on the best interest of the child. The findings indicate that NGOs render these services.

6.5.2 Social Assistance Act No. 13 of 2004

Almost all (19, or 90.5%) of the participants indicated their familiarity with the **Social Assistance Act No. 13 of (2004)**. This shows that they are aware that HIV and Aids-affected households suffer dire poverty and require social assistance in the form of social grants or social relief of distress to meet basic needs that are severely influenced by the consequences of HIV and that NGOs need to assist them in this regard.

6.5.3 HIV and AIDS STI Strategic Plan

More than half (14, or 66.7) of the participants were familiar with The **HIV and AIDS and STI Strategic Plan for South Africa 2012-2016**. This document has two goals, which are to address social and structural barriers to HIV and STI and to further prevent new HIV, STI and TB infection (NSP, 2012-2016:12). It also corresponds to the overall goal of the South African policies which is to alleviate the consequences of HIV and Aids for all South Africans. This shows that most of the participants' services were offered in keeping with The HIV and AIDS and STI Strategic Plan for South Africa 2012-2016.

6.5.4 Other policies and legislation

Just less than half (10 or 46.6%) of the participants indicated their familiarity with the **Constitution of the Republic of South Africa (1996),** followed by seven (or 33.3%) of the participants who were familiar with the **White Paper on Families in South Africa (2012)** and a few (four, or 19.0%) who were familiar with the **Integrated Service Delivery Model (2006)**. A few (three, or 14.3%) were familiar with the **White Paper for Social Welfare (1997)** and another two (or 9.5%) were familiar with the **Framework for Social Welfare Services (2013)**.

The results indicate that social workers at NGOs are most familiar with the Children's Act 38 of 2005 and the Amended Act 41 of 2005, the Social Assistance Act No. 13 of 2004, the HIV and AIDS Strategic Plan for South Africa and the Constitution of the Republic of South Africa (1996). These policies and legislation all contain guidelines on how to effectively intervene in the consequences of HIV and Aids in poverty-stricken communities of which NGOs should be aware.

6.6 SECTION C: SOCIAL WORK SERVICES RENDERED BY NGOS TO HOUSEHOLDS AFFECTED BY HIV AND AIDS

The Integrated Service Delivery Model (ISDM) (2006) and the Framework for Social Welfare Services (2013) equally recommend integrated social welfare services to be rendered to vulnerable people such as HIV and Aids-affected households. These services include prevention, early intervention, statutory intervention/residential/alternative care and reconstruction and after care in order to meet the welfare needs of HIV-affected households. These welfare services are provided through various professional disciplines of which social workers are the key role players. In addition, social work services by social workers at NGOs can be rendered at micro level (case work), meso level (group work) and macro level (community work) from the ecological perspective (Bronfenbrenner, 2005:37).

Theme 1: Prevention and early intervention services

The social work methods of case work, group work and community work that the participants utilise at each level of intervention in terms of the ISDM (2006) and the Framework for Social Welfare Services (2013) are important for this study and were explored. All the participants reported that they provide prevention and early intervention services at the first and second level of intervention.

Three sub-themes that emerged relate to the theme prevention and early intervention at the levels of the ecological perspective (Bronfenbrenner, 2005), namely prevention in general, prevention of mother-to-child transmission and behavioural prevention.

6.6.1 Theme 1: First and second level of intervention: Prevention and early intervention

The first sub-theme and the categories that emerged from the participants' narratives are now explored in the following section.

6.6.1.1 Sub-theme 1: HIV Prevention in general

The World Health Organisation refers to HIV prevention as practices done to prevent the spread of HIV (https://en.wikipedia.org/wiki/prevention_of_Hiv/Aids).

6.6.1.1.1 Category: 1 Micro level: Counselling and education

The findings related to the first category reveal that all the social workers at the NGOs provide prevention and early prevention services at the micro level of the ecological perspective (Berger-Weger, 2010:220), in general to individuals and couples. The following excerpts are cited in this regard:

> "We do **counselling** where we **educate** the individual about HIV transmission, the importance of testing for HIV, the consequences**,** and the availability of treatment." (Participant 16)
>
> "We **educate** each bigger boy or girl about HIV transmission when we find that the child is at risk then call the mother and **educate** her then she sign the consent form." (Participant 4)
>
> "We offer HIV education and **counselling** to **couples** who **voluntarily** asked to be tested." (Participant 5)

The above excerpts indicate that social work intervention on a micro level refers to the social workers' intervention which is focused on HIV counselling and education and involves individual persons which may be the child, mother, father or couple. The couple may be parents. The social workers' role involves counselling and education through pre-test counselling in order for the individual to give informed consent to be tested. These findings are corroborated by Van Dyk (2012:445) who confirms that pre-test counselling is done by social workers after giving someone who is considering testing for HIV all the necessary information and support to make an informed decision and give consent for testing.

What became evident from the findings is that, at micro level, social workers mainly perform the roles of educator enabler and therapist because they are providing clients with information to enable them to deal with the consequences of HIV and Aids (Kirst-Ashman, 2013:110; Johnson & Yanca, 2010:214).

6.6.1.1.2 Category 2: Meso level intervention

As with to the findings of the first level of social work services, all the social work participants indicated that their NGOs render meso level intervention in terms of the ecological perspective (Nash et al., 2005:580) to HIV affected families. They also indicated that it is one of their

primary methods of intervention as their main aim is to reduce HIV infection amongst school-going children and pregnant mothers. The following categories reflect this:

> "We offer HIV education, **counselling** and testing to **couples in groups** who **voluntarily** asked to be tested." (Participant 5)
>
> "We also **educate teenagers in groups** at schools about HIV transmission and the use of contraceptives." (Participant 4)
>
> "Some of the women come to the centre and are **pregnant,** we then have a **group session** with them where we **educate** them about mother to child transmission then refer to the clinic to be tested and commenced on art." (Participant 21)

Intervention at meso level offered by participants corresponds with the NSP 2012-2016 that recommends HIV services at a meso level to be rendered to the key population that includes young women between the ages of 15 and 24 years, as well as pregnant mothers.

It is evident that the roles of enabler and educator mainly are used by social workers at meso level (Kirst-Ashman, 2013:110) and that support groups are used to provide information about risks of HIV and Aids and prevention of transmission (Healy, 2012:137).

Although these groups address the consequences of HIV and Aids and empower group members, as required by the mission of some organisations, therapy or self-help groups that are suggested by Hepworth et al. (2006:14) do not form part of the services offered by NGOs, therefore the role of therapist is not deliberately performed.

6.6.1.1.3 Category 3: Macro level: Awareness of safe sex

Nash et al. (2005:55) refer to the macro level of intervention within the context of the ecological perspective as involving social structures that deal with gender issues, discrimination, beliefs, culture, political issues, tradition, economic and religious matters that, in most instances, hinder prevention and adequate response to the HIV and Aids epidemic. The following narratives illustrating how awareness of safe sex services are rendered at macro level while performing the role of the teacher and enabler (Nash et al., 2005:55) are cited in this regard:

> "We provide individuals and couples in the communities with male and female **condoms** and **educate** them on how to **use the condoms safely**." (Participant 4)

> "We provide every person with a pamphlet **to read** at home as well as a booklet on **condom use, HIV transmission** and **sexually transmitted diseases**." (Participant 1)

In this regard it should be noted that Kirst-Ashman (2013:39) explains that men often refuse to use condoms as they believe that real men do not use condoms because it inhibits erection and pleasure and that it spreads HIV and Aids. NGOs therefore should be aware of this when safe sex is promoted by means of macro level services and when they perform the role of teacher as explained by Johnson and Yanca (2010:24).

6.6.1.2 Sub-theme 2: Prevention of mother-to-child transmission

The second sub-theme that was identified within the theme prevention and early intervention was that of prevention of mother-to-child transmission. According to Stine (2013:22) and Rohleder et al. (2009:184), the first mode of transmission of HIV in children is mother-to-child transmission and the majority of HIV-infected children under the age of 13 years acquire HIV from their infected mothers during pregnancy, at the time of delivery, or after birth through breast feeding. The categories derived from the narratives of the participants are presented below.

6.6.1.2.1 Category 1: Micro level: Counselling education and treatment

The findings of the sub-theme prevention of mother-to-child transmission encompassed repeated references by participants indicating that they all render prevention and early intervention services to pregnant mothers to prevent transmission to the child at a micro level, meso level and macro level of the ecological perspective (Bronfenbrenner, 2005:37). This is what they said pertaining to micro-level intervention:

> "**Each pregnant mother** is **educated** about mother-to-child transmission and immediately started on **treatment** to prevent infecting the unborn fetus when the HIV results are positive." (Participant 15)

> "After a positive HIV result, we **educate** and refer **each pregnant mother** to the nursing station to be commenced on **treatment**." (Participant 14)

> **"We** will **continuously counsel** the mother about the importance of taking the **treatment**." (Participant 6)

These findings compare with The National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and Management of HIV in Children, Adolescence and Adults (2014:22) which recommend that all pregnant women or women attending the antenatal care be offered an HIV test and be provided with information about HIV testing and prevention of mother-to-child transmission, safe sex, maternal nutrition, new-born care and feeding options. This is in line with the 20-year vision of the NSP 2012- 2016. which is to reach zero new infections due to HIV transmission from mother to child.

As with prevention in general, it became evident that social workers perform the roles of educator, enabler and therapist at micro level (Kirst-Ashman, 2013:110).

6.6.1.2.2 Category 2: Meso level: Education

All the participants indicated that education is offered to all pregnant mothers in **groups** attending clinics and hospitals. Participants said:

> "Mother to child transmission **education** is done with **all pregnant mothers in groups** at the **clinics** and **hospitals** in all our areas." (Participant 19)
>
> "The local clinic refers HIV positive mothers … for further HIV **education** and adherence issues to our support **groups**." (Participant 6)
>
> "I often discuss with all the HIV positive women about their desire to have children and **educate** them about the importance of informing the Doctor." (Participant 7)

The findings emphasise the role of the social worker to educate the pregnant mother in groups about the importance of adherence to treatment and in this way promote social and individual change (Healy, 2012:137) and also to provide them with an opportunity to support each other.

6.6.1.2.3 Macro level: Awareness of safe sex

In the HIV and AIDS context in South Africa, Nash et al. (2005:55) refer to the macro level as societal structures that deal with gender issues, discrimination, beliefs, culture, political issues, tradition, economic and religious matters that, in most instances, hinder prevention, and an adequate response to the HIV and AIDS epidemic. The following are the participant's responses about prevention services that are rendered at macro level to raise awareness of safe sex:

> "All pregnant HIV-positive mothers are immediately commenced on **treatment** and encouraged to **adhere** to it as well to **use condoms** throughout their pregnancy." (Participant 6)

> "We provide every pregnant mother with a pamphlet **to read** at home as well as a booklet on condom use, a healthy diet and how to prevent the baby from infection." (Participant 1)

This finding shows that, because of the availability of treatment, the unborn fetus may be prevented from contracting HIV through mother-to-child transmission, the life of both mother and child may be prolonged after birth. The social workers' role is mainly to raise awareness about the availability of treatment in the community, as is explained by Van Dyk (2012:304-305).

6.6.1.3 Sub-theme 3: Behavioural prevention methods

The third sub-theme indicates that the most prominent and standard manner of HIV prevention and early intervention that is used is behavioural methods. This concurs with the aims of the HIV and AIDS and STI Strategic Plan for South Africa 2012-2016, which seeks to prevent both sexual and vertical transmission of HIV and STI by increasing access to medical circumcision for adults and neonates, as well as to promote the use of both male and female condoms.

All the social workers indicated that they are practising prevention and early intervention by means of behavioural methods at micro, meso and macro level. The three categories that emerged are discussed next.

6.6.1.3.1 Category 1: Micro-level intervention: Education

The findings related to the first category on education of behavioural prevention at micro-level intervention (Bronfenbrenner, 2005:37) are:

> "We **educate** each teenage girl with or without an STI about STIs **condom use** and **demonstrate** how to use **male and female condoms** as well as the use of contraceptives." (Participant 2)

> "We individually **educate** the adolescents who report to us that they are sexually active about HIV and Aids transmission and the importance of **practicing safer sex**." (Participant 2)

It is evident that education is the key intervention used for prevention and early intervention as the focus is not only to provide information but to change people's attitudes and behaviours through teaching them skills in order to empower them to prevent them from becoming HIV infected, as well as to help them to care for other HIV-positive people through the knowledge gained (Van Dyk, 2012:152).

6.6.1.3.2 Category 2: Meso level of intervention: Education

The following excerpts are cited with regard to behavioural prevention education at meso-level intervention:

> "We have bigger **girls and boys** at our facility some are HIV positive and some are not, we **educate** and **demonstrate** to them about condoms use and the use of contraceptives **in groups**." (Participant 4)
>
> "We also **educate couples** and encourage them to use both male and female condoms." (Participant 19)

The social worker's role is to educate individuals or couples in groups about effective condom use in order to prevent infection and empower women to use female condoms, as well as using contraceptives, to prevent pregnancy. This view is supported by the recommendation in the National Strategic Plan (2012-2016:19) that using condoms should not be the only intervention and that information on other forms of contraceptives should be provided (Kirst-Ashman, 2013:39).

6.6.1.3.3 Category 3: Macro-level intervention: Awareness of safe sex

The findings related to the third category are about awareness of safe sex at macro-level intervention. Two participants are cited:

> "We distribute **free male and female condoms** at all our facilities and testing sites, we educate the girls about their **rights** and encourage them to use female condoms." (Participant 10)
>
> "We provide every person with a pamphlet **to read** at home as well as a booklet on **condom use, HIV transmission** and **sexually transmitted diseases**." (Participant 1)

The findings about education at meso level also apply at macro level. The social worker acts as an educator at macro level to teach the community about safe sex and the need to use condoms (Nash et al., 2005:55).

6.6.2 Theme 2: Third level of intervention: Statutory, Residential and Alternative Care

The consequences of HIV for households have been discussed in Chapter 2. These consequences often affect the ability of parents to care for their children. Hence statutory intervention is often needed. Section 148(1) of the Children's Act No. 38 of 2005 states that a children's court may order that the child be removed. Section 151(2) of the Children's Act, in addition, makes provision for the court to order that a child in need of care and protection is placed in temporary safe care to secure the child's safety and wellbeing. From the second theme, the third level of intervention, one sub-theme was identified and within this sub-theme two categories emerged to substantiate this sub-theme. These are discussed next.

6.6.2.1 Sub-theme 1: Micro-level intervention: Statutory service

According to the New Dictionary of Social Work (1995:62), statutory social work refers to social work services that are rendered to individuals, families and communities in order to enhance their social functioning through following legal procedures as prescribed by the law. When investigating how the NGOs render statutory Social Work services to HIV-affected households to ensure the care, protection and welfare of children and carers, the following two categories emerged.

6.6.2.1.1 Category 1: Involvement in children's court enquiries in terms of the Children's Act No. 38 of 2005

The findings related to the first category reveal that all the participants reported that they are not involved in rendering court enquiries services in terms of the Children's Act no 38 of 2005 at micro level. This is the response of one of the participants to illustrate this finding:

> "We are **not involved** in any court enquiries as the designated social worker does that." (Participant 7)

This finding corresponds with the Children's Act No. 38 of 2005 section 151(1) and section 155(5) which stipulate that it is the role of the designated social worker to investigate whether the child is in need of care and protection and to bring the child to court. The fact that

participants in this study are not acting as designated social workers in terms of this Children's Act is a surprising finding.

6.6.2.1.2 Category 2: Involvement in temporary safe care services

Findings related to the second category similarly indicated that most of the social workers did not render temporary safe care services at the micro level of the ecological perspective (Bronfenbrenner, 2005:37).

The Children's Act No. 38 of 2005 section 151(1) refers to temporary placement as a placement arranged when a child is in need of care and protection for a short period of time. This situation, according to section 155(7b), should be referred within 24 hours for investigation by a social worker.

The findings indicate that three quarters of participants are not involved in rendering temporary care services in terms of the Children's Act to HIV-affected children and families. The following excerpt is cited in this regard:

> "We are **not involved** in temporary safe care service as we are not registered as a temporary safe care facility." (Participant 7)

Although some participants reported that they are registered as a temporary safe care facility, they are also not qualified to act in the capacity of a designated social worker, as can be seen in the narratives below.

> "We are a temporary safe care facility however the children are placed by the police or an external social worker when the removal is **an emergency** and the **child's life is in danger**. We will then contact the **designated social worker** to render the services like going to court with the child and will ask our carers to accompany the designated social worker for support." (Participant 3)

These findings are supported by the Children's Act No. 38 of 2005 section 151(1) that states that only a designated social worker may investigate whether the child is in need of care and support and may remove the child with or without a court order. In addition, section 177(3) confirms that premises that render temporary care services need to be registered with the Department of Social Development and meet the requirements, which is illustrated by the narrative above.

It is evident that statutory intervention services are only rendered to children where there is a crisis or early intervention has failed to meet the care and protection needs of these children and that the designated social worker is responsible for arranging the placement at a registered facility and not the social worker at the temporary safe care facility.

6.6.2.2 Sub-theme 2: Macro level intervention: Residential care

Weinberg (1983:1) refers to residential care or group homes providing services such as physical care, psychological support, shelter and any required services rendered under the supervision of the carer at the macro level of the ecological perspective (Bronfenbrenner, 2005:37). Furthermore, section 58(1) of the Children's Act No. 38 of 2005 recommends that the child be placed in a residential programme that will meet the child's basic needs, such as medical and psychological needs.

The participants were asked to tell how the organisation is involved in rendering residential services to HIV and AIDS-affected households, either by offering residential care or referring children to residential facilities. Three categories were identified from the sub-theme and these are discussed:

6.6.2.2.1 Category 1: Involvement in residential care facilities

The findings reveal that most of the participants indicated that they were not from residential facilities, but did refer children in need of care to designated social workers at other NPOs when they found that the parent's or parents' care did not meet the medical and psychological needs of the HIV-positive child. The following narratives reflect this:

> "We refer to the **Department of Social Development**." (Participant 3)
>
> "We are not involved, but we do write reports to the **designated social worker** on request." (Participant 3)

A small portion of participants, however, indicated that they are involved in rendering residential care to HIV-affected households. These participants' narratives illustrate this:

> "We are registered as a **residential facility or children's home**." (Participant 2)
>
> **"**We currently have 107 children in our residence that are placed by the designated social workers and we render **care and support services** to them." (Participant 2)

> "We have **different homes in the communities** where we accommodate vulnerable children and render **support services** to them and their families." (Participant 10)

These findings are confirmed by section 191(1) of the Children's Act No. 38 of 2005, which refers to a child and youth care centre as a facility that provides residential care to more than six children outside the family home in order to meet the basic needs of the child as may be the case with children in HIV-affected families.

Furthermore, the findings reveal that there are various residential care facilities that offer different care and support services to children as based on their needs. Therefore, social work intervention by social workers at NGOs should be directed by the needs of the children and the mission of the organisation.

6.6.2.2.2 Category 2: Involvement in group homes

Muller and Steyn (1990:30) refer to a group home as a single dwelling housing a small group of children who are cared for by either a trained couple or housekeeper who are and who get a salary. Furthermore, these group homes are ordinary houses situated in a residential area where inhabitants perform as a normal family.

The findings reveal that most participants indicated that they are not involved in group homes services to HIV-affected households. However, they do refer these children to a designated social worker at an NGO in terms of the requirements of the Children's Act. One participant responded as follows:

> "We only render services to the communities, but they do not stay on our premises, therefore we refer those in need of care to the **designated social workers**." (Participant 17)

A few participants indicated that they do render group home services. The following narratives illustrate this:

> "We do have various **cluster foster care homes** in our communities and a trained carer for each home of six children who is in receipt of a stipend monthly." (Participant10)

> "We render the same **care and support services** to them as with all the children as well as **emotionally supporting the carers** through **training** in order to gain **skills** to adequately care for these children." (Participant 10)

The findings reveal that some participants render services to HIV and Aids-affected children that either reside with their parents or with family members in the community and that the participant was only involved in cluster foster care in a supervising capacity.

6.6.2.2.3 Category 3: Registration as Child and Youth Care Centres

The Children's Act No. 38 of 2005, section 191(1) refers to a Child and Youth Care Centre (CYCC) as a residential care facility that offers residential care to more than six children outside the family and meets the basic needs of the children.

The findings reveal that the majority of the participants were not from a facility registered as a CYCC, but that they did refer children to the designated social worker if they identified a need for such placement. The following narratives reflect this:

> "No, we are not a **child youth care centre**, but we work with the external social workers by providing reports on request and supporting the child when attending the court procedures." (Participant 9)

A few participants however indicated that they are employed at a registered CYCC. The following narratives reflect this:

> "We do accommodate children with **chronic illnesses** who defaulted on their treatment due to **poor social circumstances, neglected** and **abandoned children**." (Participant 20)

> "The Department of Social Development do refer to our CYCC for only **psychosocial reasons**, we then refer them to our skills programmes while they are **awaiting transition** to other facilities." (Participant 1)

This finding echoes the Children's Act No. 38 of 2005, sections 191 2(d) and (e) and sections 3(a) (b) and (e). This finding is also supported by Moses and Meintjes (2010:109) who conducted a study in the Western Cape that revealed that six percent of children above 18 years continued to stay in the facility following special arrangements between the social worker and the court.

It is also evident that the above placements are temporary as the aim is to protect and care for the child while in dire need. Hence proper assessment needs to be conducted in order to determine the future placement of the child and siblings, as required. This requires social workers at NGOs to be familiar with the requirements of the Children's Act.

6.6.2.3 Sub-theme 3: Alternative Care

The Children's Act No 38 of 2005 section 167(a), refers to a child in alternative care as a child placed in foster care (b) in the care of a Child and Youth Care Centre and 3(b) with a person, place or premises of safe care only when ordered by the court. The participants were asked to tell how their organisations utilise foster care placement and adoption. The two categories that emerged from the analysis of the interviews were related to how NGOs use alternative care for HIV-affected households, as follows:

6.6.2.3.1 Category 1: Involvement in foster care placement

In South Africa kinship foster placement is a long-established traditional practice usually provided by grandparents. However, due to ill health as well as the inability to care for children of HIV affected households, these children come to be in need of care and protection and then are often placed in foster care with non-relatives.

Section 180 of the Children's Act No. 38 of 2005 refers to a child in foster care as a child who is placed in the care of a person who is not the parent or guardian of the child by the court.

Although almost all the participants indicated that the majority of the children from HIV-affected households to whom they render services are placed in foster care by designated social workers of other NGOs, they do provide training to prospective foster parents: The following narrative reflects that some participants are involved in foster care, but only in training and recruitment.

> "We are **training and recruiting prospective foster par**ents that are referred by the Department of Social Development or self-referred." (Participant 14)

This finding corresponds with Hall, Woolard, Lake and Smith (2012) who confirm that social workers could be involved in processing foster placement applications, screening or training of foster care parents.

Other participants responded that they were not involved or referred children of HIV-positive families.

> "We are **not involved** in **foster placements** but we do write reports to the designated social workers on request when the child is attending our programmes as most of our children are placed in foster care with their aunts and grannies." (Participant 6)

> "Most of our children are already in foster care, we **refer** them to the Department of Social Development with a report when there is a need." (Participant 20)

It is evident that the social worker plays a crucial role in training the prospective foster parents to prepare them to be able to deal with HIV-affected children (Kirst-Ashman, 2013:131; Hall et al., 2012:3).

Moreover the findings reveal that the role of the social worker in terms of foster placement could be to write required reports about the family for referral purposes, as was reported by some participants. The social worker's role is also to maintain close contact with the biological mother or parents of the child for the purpose of family reunification.

6.6.2.3.2 Category: 2 Involvement in adoption

Another form of alternative care is adoption. A child can be adopted when all parental responsibilities and rights of all persons related to the biological parent or parents are legally terminated and the child is placed in the care of another person who will legally take on parental responsibilities for the child and the child's rights (Children's Act No. 38 of 2005, sections 228 and 242). The participants were asked to explain how their organisations utilised adoption.

The findings reveal that most participants indicated that they were not involved in arranging adoption; they refer all enquiries related to adoption to adoption centres. The following statement explains a participant's involvement in adoption:

> "We do **educate** people who inquire about both adoption and foster placement and discuss the consequences and we **refer** them to the nearest adoption centres." (Participant 3)

It is evident that participants mainly perform the role broker in the case of adoptions (Kirst-Ashman, 2013:303-304).

In addition to this finding, some participants revealed the following:

> "The people in our communities are not interested in adoption due to **cultural differences** as they fear to take children from a different clan unless, if it is their family member's child, they **will just take the child**." (Participant 16)
>
> "Our children are not always possible candidates for adoption due to their **HIV positive status**." (Participant 10)

It is worth noting that the practice of adoption used not to exist in African countries; in the African culture it is a norm that the family members left behind when parents die decide who will take care of the children (Grannis, 2010:13). The findings reveal that adoption is not a normal practice as children are naturally cared for by family members as in foster care.

Some of the findings concur with Abdool Karim and Abdool Karim (2010:363) who confirm that adoption of HIV-affected children is not considered often due to stigma attached to HIV and Aids.

It is evident that social workers in NGOs rendering services to HIV-affected households are not involved in statutory, residential and alternative placement as this involves court processes. However, they do render services to those children who attend their programmes or are admitted at their residential facilities. The role of the social worker in this regard is to support fulfilment of the children's survival needs, as well as their need for education, thus taking on the roles of educator, enabler or broker (Kirst-Ashman, 2013:303-304).

6.6.3 Theme 4: Reconstruction/ Reunification and after care

The fourth level of intervention recommended in the Integrated Service Delivery Model (2016) and the Framework for Social Welfare Services (2010) is reconstruction/ reunification and after care. The ISDM (2016) and the FSWS (2013) recommend these social welfare services to be rendered following alternative or statutory care services so that the child can return to his or her family or community, and to offer further support services which may be required to ascertain optimal social functioning and independency. These services can include community home-based care services and various other services such as community-based care, drop-in centres, support programmes and home visiting. One theme emerged from Theme 4, namely how the NGOs offer after care services to HIV-affected families after alternative or statutory placement. One sub-theme and five categories were identified and are discussed next.

6.6.3.1 Sub-theme 1: After care services

The first sub-theme is aftercare services. The one category identified under this sub-theme is discussed here.

6.6.3.1.1 Category 1: Provision of community-based care services

Community-based care services by NGOs are normally rendered to HIV and Aids-affected households after discharge from a health facility and after alternative placement.

Van Dyk (2012:344) refers to home-based care as any form of care given to ill people in their homes by formal and informal care givers. Both home- and community-based care assure a continuum of comprehensive health and community care services provided in homes and the community in order to ensure that a person or a family experience an optimal level of comfort, social functioning and health. In addition, the Department of Social Development (2003:41) recommends that, in order to ensure effective community home-based care services, training for all community-based care givers is essential.

Almost all participants confirmed that their NGOs provide community-based care services to HIV affected households in the communities. Some of them said:

> "We do have **trained community based care workers** at our facility that conduct home based care services to children and adults after discharge from our respite care and provide them with services such as fetching their **medication** from the clinic, bathing them and giving them their **TB treatment** daily." (Participant 4)

> "We do have **community home based carers** who works very close with the clinics as the clinics will send them to find families who is not coming for their treatment to the clinic." (Participant 13)

These findings support findings by Uys and Cameron (2003:6) indicating that community homebased-care programmes are normally run by volunteer care givers affiliated to an NGO, a community-based organisation or a faith-based organisation.

In contrast, a few participants reported that they did not render home-based care services to individuals in the communities. They said:

> "We **refer** individuals to the local clinics for home based care services." (Participant 8)
>
> "When the families come to us very weak or report a sick family member at home we **refer** to … for home base care services." (Participant 14)

Furthermore, these findings are significant because HIV and Aids is a progressive illness, therefore constant monitoring and supervision of treatment adherence is ideal in order to prolong people's lives and to facilitate optimal functioning and independency (Van Dyk, 2012:121). From the findings reported above it is evident that participants refer HIV positive families for home-based care in order to ensure that the individuals receive the necessary support. The social worker's role i then is that of a broker (Kirst-Ashman, 2013:303-304). In addition the findings show that NGOs are concerned with networking with other role players as is stated in the mission of the organisations.

6.6.3.2 Sub-theme 2: After school care services

The second sub-theme identified within the theme after school care services where services are rendered to HIV and Aids affected households in order to provide care, protection and to assure that their welfare needs are met.

According to Grannis (2011:133), after school care centres normally consist of a single facility where HIV counselling and education services can be received by people. These centres also usually offer children meals, support with homework, and a safe place for fun activities after school and possibly also support group activities. The following categories emerged from the sub-theme and are now discussed.

6.6.3.2.1 Category 1: Provision of meals to children

All participants indicated that they do provide meals in different forms for the children and their families. These are some of the participants' responses:

> "We have a **feeding programme** for our preschool children; child headed household children and all the other children and adults that are our beneficiaries on a daily basis." (Participant 5)

> "We do have our own **vegetable garden** that we cook from and a bakery that bakes **bread** for the children to eat after school as well as taking a loaf of bread home daily." (Participant 7)

These comments show that NGOs are aiming to meet survival needs by means of providing food to families in order to meet their basic needs as required for poverty alleviation in terms of the White Paper for Social Workers (1997), the White Paper on Families in South Africa (2012) and the mission of the NGOs.

6.6.3.2.2 Category 2: Provision of homework assistance

As with the first category, all participants indicated that they offer homework assistance to beneficiaries. They explained that children are referred from various schools in their area and any child who requests homework assistance in their service delivery areas will be assisted. The following responses reflect this:

> "This programme is utilized by all the children in this area who require **homework assistance** and they are referred by the school or self-referred." (Participant 15)

> "We do have volunteers from our local schools, retired teachers, from abroad as well as from our gap year residence that assists **with homework**, **reading skills** and **activities to stimulate the brain** daily." (Participant 3)

The comments reveal that assistance with homework is offered by after-school facilities because children need support with their education, which is one of the consequences of HIV and AIDS for affected households. Guidance and support with homework is essential for these children to reach future goals and independency (Carbone, 2009:27).

6.6.3.2.3 Category 3: Provision of school holidays and safety programmes

With regard to school holidays and safety programmes all participants indicated that they offered these programmes to the children in need of this service in service areas. This is what they said:

> "Our **school holiday programmes** are in June, September and one week during Easter weekend." (Participant 6)

> "All children are allowed and we mostly focus on **safety programmes** like **sexual abuse** and **how to react to strangers at home and in public places**." (Participant 6)

> "We take them out weekends and during school holidays to the malls, zoo, Table Mountain and [for] other **educational excursions**." (Participant 5)

The programmes mentioned above provide children with educational activities and safety, as well as keeping them away from negative environments. These activities all concur with section 28(fii) of the 1996 Constitution of the Republic of South Africa that recommends that the child should not perform work or provide services that place the child's wellbeing, education, physical or mental health or spiritual, moral or social development at risk. Article 31 of the United Nations Convention of the Rights of the Child (1989) similarly affirms the right of the child to participate in a range of cultural, artistic and other recreational activities.

6.6.3.2.4 Category 4: Provision of support and income-generation groups

Support groups focus on verbal challenges, exploration and psychosocial counselling. The support group programmes are normally combined with activities that are directed at income generation (Uys & Cameron, 2003:82). These income-generating activities can include making beaded ribbons, paper bowls, table cloths, gardening, and making foodstuffs.

All participants indicated that they are availing support groups preferable to HIV children and affected households. The following excerpts are cited in this regard:

> "We initiated a HIV-positive **women support group** at the organisation that is **unemployed and does not qualify for a grant**." (Participant 6)

> "We teach those **sewing skills and beading skills** in order to develop **employment skills** and they are receiving a **stipend**." (Participant 6)

> "The **gardening skills project** is for any community member who is interested in gardening and we also use the vegetables to cook a **nutritious diet** for the beneficiaries and community members daily." (Participant 7)

> "We also initiated **support groups for HIV-positive children, adults** and **families** where we deal with adherence issues, emotional issues and educating the families about how to deal and cope with a HIV-positive family member." (Participant 20)

The findings reveal that these support groups provide various benefits such as emotional support, sharing of ideas, empowerment and acquiring skills in order to generate income. The social worker's role is to initiate these support groups after having made an assessment based on community needs (Kirst-Ashman, 2013:110).

6.6.3.2.5 Category 5: Provision of home-visiting services

As with community home-based care, HIV-affected households are visited at home by home-based carers who can offer education to the HIV-patient and his or her family regarding how to provide for their basic needs (Uys & Cameron, 2003:118). The carer can provide support with house cleaning, cooking, accompanying patients to health care centres, fetching their medication, helping with errands, arranging for food parcels and to provide for other material needs (Russel & Schneider, 2000:331). The following are the participants' responses in this regard:

> "After discharge from the residential facility the social worker and the nurse will **do home visits** to see if they are compliant with their TB and Antiretroviral treatment and continue supporting them **with food and material needs**." (Participant 8)
>
> "When the families are discharged from our programme after a year, we **visit them** quarterly and if the social circumstances have not changed we reregister them to the programme." (Participant 6)

The findings give a clear indication that aftercare services are essential after discharge from the hospital, respite care or residential care as aftercare services offer continuous services that allow family members the opportunity to gain skills and knowledge about how to care for their families. In addition, and more crucial in the case of the children, is that services such as providing meals are fundamental to children as a nutritious diet enables the child to concentrate and be stimulated in order to develop.

It can be concluded that after-care services involve a continuum of comprehensive services that are rendered by NGOs to HIV affected households in order to maintain their optimal functioning within their communities.

6.7 CONCLUSION

This chapter has set out the exploratory and descriptive study of social work services rendered by NGOs to HIV-affected children and households. A total of 21 participants were selected through purposive sampling. The interview schedule was based on the literature review discussed in Chapter 2, Chapter 3 and Chapter 4 of this study. The data are presented in the form of tables, interpreted and contextualised in terms of the literature review. These findings were then utilised to produce conclusions and recommendations on the social work services rendered according to the ecological perspective by NGOs to HIV-affected households.

CHAPTER 7:

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The goal of the study was to gain an understanding of social work services rendered by social workers in NGOs to households affected by HIV and Aids. Chapter 6 presented the empirical findings of the study and this section presents conclusions and recommendations based on the findings.

This chapter therefore fulfils objectives four and five of this study. These objectives were:

Objective 4

To investigate, from an ecological perspective, the nature and extent of social work services rendered to households affected by HIV and Aids by social workers in various NGOs in the Cape Metropole.

Objective 5

To make recommendations for the promotion of social work services to households affected by HIV and Aids.

These objectives were achieved through the implementation of the other objectives of this study, which were dealt with in the second, third and fourth chapters, which were:

Objective 1

To explain the phenomenon and consequences of HIV and Aids for affected households and to describe the ecological perspective as theoretical framework for the study.

Objective 2

To discuss how policies and legislation make provision for social work services rendered to children and households affected by HIV and Aids.

Objective 3

To describe the social welfare services mandated by government and rendered by social workers in NGOs to households affected by HIV and Aids.

This section presents the conclusions and recommendations of the study based on the empirical findings presented in Chapter 6. Findings regarding an overview of the participants' profiles are presented, followed by findings regarding the themes which were explored in the study. These themes include a profile of NGOs, needs of households affected by HIV and Aids and services provided by NGOs, familiarity with policies and legislation related to HIV and Aids and social work services rendered by NGOs to households affected by HIV and Aids.

The recommendations are aimed at improving social work services rendered by NGOs to HIV affected households within the context of an ecological perspective.

7.2 SECTION A: PROFILE OF PARTICIPANTS

Participants provided certain identifying details to ascertain their competency in rendering social work services to HIV-affected households. These included their qualifications, training related to HIV and Aids, work experience and registration of the NGO.

7.2.1 Qualifications

All of the 21 social workers who participated in the study were social workers with qualifications ranging from a Diploma in Social Work to a Master's degree in Social Work.

Conclusion

The findings of the study indicated that qualifications of the social workers meet the registration requirements of the South African Council for Social Services Profession (SACSSP) for practising as social workers.

7.2.2 Training related to HIV and AIDS

All the participants obtained training related to HIV and Aids, such as HIV counselling and care, HIV counselling and testing and adherence counselling.

Conclusions

HIV counselling and care and adherence counselling do have relevance for the social work profession as social workers need to offer counselling and education in order to educate HIV-affected households about HIV and Aids, as well as to educate them about available treatment in order to prevent HIV transmission and to prolong the lives of those already infected. Although HIV testing is not a social worker's task, social workers do need to understand the HIV testing procedure in order to be able to educate HIV-affected households about the need for HIV testing and of the benefits of testing for them.

Recommendations

Social workers should attend HIV and Aids-related training such as administering treatment in order to emphasise adherence to treatment during follow-up sessions with clients or with support groups.

The social work education curriculum should contain a clinical or health module in the undergraduate social work programme in order to introduce students to health issues related to HIV and Aids and to social work service intervention that is needed.

7.2.3 Work experience

More than half of the social workers had work experience of between one and six years and only three had more than 25 years' work experience.

Conclusions

The majority of social workers employed at the various NGOs are social workers with less than seven years' experience, but they, as seen above, had relevant qualifications and training related to HIV and Aids.

Recommendations

NGOs should implement practices and relevant training to retain social workers to work in the field of HIV and Aids.

7.2.4 Experiences of social workers working in the field of HIV and Aids

Findings reveal that more than half of the social workers have one to six years' experience of working in the field of HIV and Aids and four social workers had more than 22 years' work experience in the field of HIV and Aids.

Conclusions

Most of the social workers had worked in the field of HIV and Aids for as long as they had been doing social work, indicating that they were less experienced. There seemed to be a huge gap between the number of less experienced and more experienced social workers in the NGOs.

Recommendations

NGOs should offer regular supervision and training to equip social workers and to give them the necessary support required for rendering social work services to HIV and Aids-affected households.

7.2.5 Registration of Organisation

Findings reveal that all the social workers are employed by NGOs that are registered in terms of the Act on NPOs (Act 71/1997).

Conclusion

The fact that all the NGOs are registered is an indication that all the social workers are mandated to render social work services to HIV-affected children and households.

7.3 SECTION B: PROFILE OF NGOs

This section explores the mission of the NGOs, the sources of funding of NGOs, the utilisation of funding for services and the client base of NPOs. As indicated in Chapter 3, NGOs have been established to address the HIV and Aids crisis in South Africa and engage in a variety of service delivery in order to alleviate the consequences of HIV and Aids. The findings related to the four themes identified in this section are discussed below, followed by conclusions and recommendations.

7.3.1 Theme 1: Mission of the organisations

Under this theme, three primary sub-themes became apparent from the findings of the study; the first being networking, the second poverty alleviation and the third empowerment. The mission of all the NGOs is to collaborate with the various NGOs in order to effectively alleviate poverty and to empower HIV-affected children and households.

7.3.1.1 Sub-theme 1: Networking

The majority of the participants indicated that the mission of their organisations is networking and collaboration with other stakeholders.

Conclusion

Networking and collaboration with relevant role players is essential in order to holistically attend to the needs of HIV-affected children and households. This is in line with the requirements of the ISDM (2006) and the Framework for Social Welfare Services (2013).

Recommendation

NGOs should maintain networking and collaboration with relevant role players in communities to enable them to meet the needs of HIV and Aids-affected households.

7.3.1.2 Sub-theme 2: Poverty alleviation

Findings showed that the mission of most of the organisations is focused on poverty alleviation.

Conclusions

It is confirmed in Chapter 2 that children affected by HIV normally come from poor backgrounds and experience poverty and that social workers in NGOs render services to both urban and rural populations who experience poverty. In addition the White Paper for Social Welfare (1997), The White Paper on Families in South Africa (2012) and the Social Assistance Act No. 13 of 2004 equally recommend poverty alleviation through providing families with basic needs and social assistance and social security. Therefore poverty needs to be addressed in order to effectively deal with the consequences of HIV for children and affected households.

Recommendation

Poverty alleviation programmes should constantly be introduced by NGOs in poverty restricted areas to all members of the communities, and especially for HIV and Aids affected households.

7.3.1.3 Sub-theme 3: Empowerment

Some participants stated that the mission of the NGOs is to empower vulnerable people such as HIV-affected households and to empower communities.

Conclusions

Because families in communities where NGOs operate often are vulnerable people they need to be empowered to reach optimal functioning. Hence NGOs should note that the White Paper on Families in South Africa (2012) and the ISDM (2006) recommend services to be directed to vulnerable children and families such as HIV-affected households and intervention should focus on prevention, early intervention, alternative care and reconstruction and after care for families to reach a desired level of functioning.

Recommendation

NGOs should involve families in communities in programmes that can promote their own wellbeing and to empower them to become more self-reliant.

7.3.2 Theme 2: Sources of funding of NGOs

Under sources of funding, the second sub-theme, four sub-themes related to the nature of funders were identified from the findings, namely subsidy from state departments, the lottery, corporate sectors and foreign funders. All the participants indicated that they are funded from these sources in order to sustain the organisation's functioning.

7.3.2.1 Sub-theme 1: Subsidy from state departments

The findings reveal that the funding from state departments includes subsidies from the Department of Health, Department of Social Development and the Department of Education.

Conclusions

The sources of funding of NGOs are in line with Non-Profit Organisation Act 71 of 1997 in terms of which NGOs are registered and qualify for subsidy. This kind of funding is received from the South African government, which indicates government's involvement in fighting the battle against HIV and Aids. However, how much of the funding is allocated for social service delivery per NGO or HIV and Aids-affected household. is not clear.

Recommendation

It is recommended that NGOs stipulate clearly what funding each state government department is providing to them as transparency is crucial in terms of government that are meant to assist all South Africans, and especially HIV and Aids-affected households.

7.3.2.2 Sub-theme 2: Lottery

Findings showed that all NGOs also receive funding from the Lotto in terms of the Lotteries Act No. 57 of 1997, which demonstrates that they are eligible to apply for funding from the National Lotteries Commission.

Conclusion

The fact that all registered NGOs qualify to receive funding from the Lotto shows that it is another source of viable funding.

7.3.2.3 Sub-theme 3: Corporate sector

The findings of the study reveal that various donors in the corporate sector, whether individuals, family businesses or large companies, provide funds for different needs of NPOs so that NPOs are able to effectively render social work services to HIV-affected children and households.

Conclusion

This finding is in line with the literature as discussed in Chapter 1 that revealed that, in addition to the government, various role players in the business sector have played a crucial role in responding to the HIV epidemic. It also indicates that collaboration with the corporate sector is crucial for effectively responding to the HIV epidemic and that they contribute in response to the epidemic

Recommendation

It is recommended that NGOs continuously approach the corporate sector for financial support to address the HIV and Aids epidemic.

7.3.2.4 Sub-theme 4: Foreign funders

All the NGOs indicated that they are also funded by foreign funders such as the United States Agency for International Development (USAID).

Conclusion

It is evident that NPOs benefit from global funding such as offered by USAID, which enables them to render welfare services to HIV and Aids-affected households.

Recommendations

NGOs need to continue to obtain and expand financial support from global funders to enable them to respond to the HIV epidemic.

7.3.3 Theme 3: Utilisation of funding for services

Findings showed that the funding received by NGOs from various sources was primarily used to alleviate poverty and to enhance empowerment of vulnerable families.

7.3.3.1 Sub-theme 1: Poverty alleviation

Findings indicate that funds are utilised for poverty alleviation, which is the focus of the mission of some of the NGOs. The categories of poverty alleviation that emerged include providing food and clothing and practical assistance to HIV-affected households.

7.3.3.1.1 Category: Food and clothing

Findings indicated that the funds were utilised to buy food and clothing, as well as school uniforms, as HIV-affected households are normally from impoverished backgrounds.

Conclusion

The findings are in line with section 28 of the Bill of Rights of The Constitution of the Republic of South Africa (1996), as well as the White Paper for Social Welfare (1997), which emphasise

poverty alleviation. Food is a basic survival need for any individual and clothing restores human dignity. Food and clothing are the most needed items among South Africans living in poverty.

Recommendation

NGOs need to obtain funding from a variety of sources to enable them to provide food and clothing to meet the needs of poor families in HIV and Aids-affected households.

7.3.3.1.2 Category: Practical assistance

Findings demonstrated that funding was utilised for practical assistance, such as transport for foster mothers to attend training, transport for beneficiaries, and also to buy electricity for the child-headed households.

Conclusion

Practical assistance is provided by NGOs to allow beneficiaries to access some of the support offered to them. Examples of these are support groups, training to equip foster parents them with skills to be able to care for children placed in foster care, as well as to support child-headed households when in need of buying electricity. It is evident that practical assistance is crucial to meet some of the welfare needs of service users.

Recommendations

Practical assistance is important and should be utilised by NGOs for the benefit of the beneficiaries in order to meet the mission of the organisation.

7.3.3.2 Sub-theme 2: Empowerment

Empowerment is identified as the second sub-theme for which funds are utilised and categories such as intervention services and residential care emerged.

7.3.3.2.1 Category: Intervention services

The findings revealed that funding was utilised for the purpose of establishing support groups for both children and adults to offer psychosocial support and for empowerment of HIV and Aids households.

Conclusion

Support groups are important as they provide the opportunity to learn from one another, as well as to emotionally support one another in order to cope with the consequences of HIV and Aids.

Recommendation

NGOs should facilitate support groups for all capable age groups of service users in order to teach children from a younger age to mutually support each other and also for adults to support each other.

7.3.3.2.2 Category: Residential care

Findings indicated that funds were utilised to build and maintain shelters for children and women, as well as to maintain Child and Youth Care Centres.

Conclusion

Empowerment of children and women are achieved through meeting their basic need for shelter and offering protection and care services to them.

Recommendation

NGOs should obtain and utilise funds for residential care such as providing shelter to meet the needs of HIV and Aids-affected children and women.

7.3.4 Theme 4: Client base of NGOs

The client base of the NGOs was explored and four sub-themes emerged. These include orphans, women, extended family members and child-headed households.

7.3.4.1 Sub-theme: 1 Orphans

The NGOs under study rendered services to children from birth to 18 years who are orphaned, or whose parents died due to HIV and Aids.

Conclusion

It is evident that services are rendered to HIV and Aids orphans in need of care and protection as stipulated in Children's Act No. 38 of 2005.

7.3.4.2 Sub-theme 2: Women

Findings indicate that some NGOs rendered services to HIV-positive women between the ages of 18 and 49 years.

Conclusion

NGOs render services to HIV-positive women, the group most affected by the HIV epidemic.

7.3.4.3 Sub-theme 3: Extended family members

The NGOs also rendered social work services to extended families because it is documented that the loss of a parent often results in children being left behind being cared for by members of the extended family, such as grannies and aunts.

Conclusion

It is evident that the responsibility to care for children who are left behind when parents die rests with members of the extended family who eventually take over their care. This automatically makes them part of client base of the NGOs.

7.3.4.4 Sub-theme 4: Child-headed households

The findings indicated that some NGOs rendered social work services to child-headed households.

Conclusion

Child-headed households, who can be defined as a vulnerable group of children, have also become part of the client base of NGOs working in the field of HIV and Aids.

Recommendation

NGOs should continue to offer welfare services to vulnerable groups such as orphans, women, extended families and child-headed households affected by the consequences of HIV and Aids.

7.3.5 Theme 5: Consequences of HIV and Aids

Under this theme, six primary sub-themes emerged from the findings of the study regarding social work services rendered by NGOs to children and affected households suffering the consequences of HIV and Aids.

7.3.5.1 Sub-theme 1: Survival and care needs

Findings demonstrated that the loss of a parent can have serious consequences for an affected child due to lack of provision for basic needs such as food, shelter, clothing, health care and education.

From this sub-theme four categories emerged, namely basic needs, responsibility of caring for children shifted to extended families, children taking responsibility for the care of siblings and victims of exploitation and abuse.

7.3.5.1.1 Category: Basic needs

Findings showed that basic needs such as shelter, food, clothes, money, lack of birth certificates and education are needs experienced in HIV-affected households.

Conclusion

The findings reflect how the unfilled basic needs lead to poverty experienced by HIV and Aids-affected families and emphasise the challenge for NPOs to address poverty as stated in their mission statements and supported by the White Paper for Social Welfare (1997) and the White Paper on Families in South Africa (2012).

Recommendation

NGOs should offer care and support services to HIV and Aids-affected households to assist them to meet their basic needs for the sake of survival.

7.3.3.5.2 Category: Responsibility for caring for children shifted to extended families

Findings indicate that the majority of children affected by HIV and Aids often are cared for by their aunts, grannies, or other children or are placed in foster care.

As seen, HIV-affected children are often cared for by grannies who in most instances are old, sickly and solely depend on a grant. This raises concerns about their ability to supervise and physically take care of the children as they get older, as well as being able to adequately care for these children. In addition, HIV-affected affected children are often cared for by other children who also require adult supervision and care.

Conclusion

The findings show that next of kin of HIV and Aids-affected households need support services offered by NGOs.

Recommendation

NGOs should continue to offer services to the next of kin of HIV-affected households.

7.3.3.5.3 Category: Children taking responsibility for the care of siblings

The findings indicate that HIV-affected children often take care of their siblings or the remaining sick or dying parent which results in depriving the child of being a child.

Conclusion

Because of the responsibilities that HIV-affected children often have to shoulder in families they can no longer be defined as children because their rights as children are violated when they have to perform adult duties and take on responsibilities which are in contrast with both the Children's Act No. 38 of 2005 and the Constitution of South Africa (1996).

Recommendation

NGOs should offer home-based care services to HIV and Aids-affected household to release children in the household from responsibility for household chores and caring.

7.3.3.5.4 Category: Victims of exploitation and abuse

Findings showed that some HIV-affected children become sexually active with adults who may provide them with money. This makes it possible that they become victims of sexual abuse or become prostitutes.

Conclusions

From the above findings it is evident that, in terms of the Children's Act No. 38 of 2005, section 110 (1), these children are in need of the protection services rendered by some NGOs.

Recommendations

NGOs should offer child protection services and education to vulnerable children in HIV and Aids-affected households at the time of parental diagnosis of HIV to protect these children from the risk of sexual abuse and prostitution.

7.3.5.2 Sub-theme 2: Emotional needs

Emotional needs result from emotional stress experienced by HIV-affected children with regard to losing a parent or caregiver.

7.3.5.2.1 Category: Emotional stress due to losing a parent or caregiver

Findings showed that most children affected by HIV develop emotional stress due to not being able to cope with the death of their parents and the causes of death; they develop fear of their own death, as well as the death of other siblings and families.

Conclusion

The need for NGOs to assist children in HIV and Aids-affected households to cope with emotions related to the death of their parents is evident from the findings.

Recommendation

NGOs should offer counselling to HIV-affected children to help them deal with the emotional stressors experienced by them to avoid future behavioural or advanced emotional problems.

7.3.5.3 Sub-theme 3: Health care needs

Health care needs as a consequence of HIV and Aids were explored and two categories emerged, namely sickness and ill health and stigma.

7.3.5.3.1 Category: Sickness and ill health

Findings indicated that the community workers often reported to social workers that HIV-infected mothers become ill because they do not take their medication and that their illness can result in stress for both the mother and child.

Conclusion

The suffering of sick HIV-infected mothers and affected children are evident from the findings. Poor adherence to medication can result in ill health; while adherence to medication may prolong life.

Recommendations

NGOs should offer continuous education to HIV-infected mothers about adherence to treatment and the consequences thereof should be emphasised. The findings also indicate the importance of aftercare offered by NGOs in order to monitor adherence and to evaluate the possibility of attending the clinic or hospital admission.

7.3.5.3.2 Category: Stigma

Stigma and discrimination are powerful forces that deter efforts to combat HIV, but it often also prohibits people from adhering to treatment and result in ill health.

Findings showed that HIV and Aids affected households often do not go to the clinics because of their fear of stigma and because women sometimes experience stigma when they are treated in separate rooms and get different folders and clinic cards.

Conclusion

The experiences of stigma at the health facilities result in HIV-affected households avoiding the clinics for treatment and this therefore results in their ill health.

Recommendation

Social workers should conduct research at health care clinics with all HIV-positive individuals about their views regarding not being treated like all other patients that attend the clinics in terms of having the same folder, having the same clinic card and being treated in separate rooms

with the intention of avoiding discrimination between them and the other patients so as to enhance adherence and prolong life.

7.3.5.4 Sub-theme 4: Educational needs

Attending school is required of all children in South Africa. However, the consequences for HIV-affected children in HIV-affected households often result in these children not being fully able to attend school.

7.3.5.4.1 Category: Missing out on school

The findings indicate that HIV affected children are missing out on school because they have to take care of their sick mothers and also because of financial constraints.

Conclusion

It is evident that the educational needs of children affected by HIV and Aids are not always fully met due to role changes and responsibilities that they need to perform in their families.

Recommendations

NGOs should make provision for children affected by HIV to be given an opportunity to further their education at a normal school irrespective of their age as they normally are delayed due to absence related to parental ill health coupled with financial constraints.

7.3.5.5 Sub-theme 5: Economic position

Findings reveal that HIV and Aids affect the economic position of affected households and result in the survival and care needs of affected households not being fully met due to unemployment and ill health.

7.3.5.5.1 Category: Unemployment

Unemployment due to poverty or ill health emerged as the major factor that affects the economic position of HIV and Aids-affected households.

Conclusion

Ill health and little or no income appear to demonstrate the economic position of HIV-affected children and households as the prevalence of HIV is higher amongst the disadvantaged and unemployed; the most impoverish persons with low skills and income.

Recommendation

It is recommend that the provision of community home-based care services such as providing meals, encouraging food gardens, and assistance in applying for grants by NGOs are essential in order to meet the needs of HIV-affected households.

7.3.5.6 Sub-theme 6: Welfare needs

Findings reveal that the consequences of HIV and Aids experienced by affected households classify them as being in need of care and support from various stakeholders as their own families are not always able to care for themselves. One category emerged under this sub-theme, namely need for care and support services outside the family system.

7.3.5.6.1 Category: Need for care and support services outside the family system

Various forms of support and care such as respite care, support services like collecting medication at clinics, bathing, treatment, education and treatment monitoring are services provided by various stakeholders outside the family.

Conclusions

Due to the extreme consequences of HIV for affected households the need for care and support services outside the family will always be of necessity. Hence findings as revealed in the previous sections confirm that affected children are those children whose parents, extended or close family have died or are not able to care for them due to ill health and various environmental factors. Thus the need for care and support is often required outside the family. This is a clear indication that HIV-affected households will always need care and support outside the family system, which will require more care and support facilities to be offered by NGOs to care and support these families.

Recommendation

NGOs should continuously offer statutory, residential and alternative care as mandated by the ISDM (2006) and the Framework for Social Welfare Services (FSWS) (2013) to care for HIV-affected families. Home-based care services and various programmes such as offered by drop-in centres, support programmes and home visiting should also be available to HIV-affected households.

7.3.6 Theme 6: Familiarity with policies and legislation related to HIV and Aids

National policies and legislation are of immense importance in South Africa and are meant to be guiding fair and just social work service delivery to all South Africans, especially to HIV-affected households. From the findings discussed in the previous section on the experiences of HIV-affected households it is evident that policy and legislation are needed in order to effectively deal with the consequences of HIV for affected households. The findings related to the various policies and related legislation are discussed below.

7.3.6.1 Children's Act No. 38 of 2005

Findings showed that all social workers who render social work services at the various NGOs are familiar with the Children's Act.

Conclusions

Children are the most vulnerable in terms of HIV-transmission as well as the most vulnerable in enduring the consequences of HIV within the household. They therefore require the continuous care and protection services recommended by policies and legislation. All the NGOs are familiar with the Children's Act No. 38 of 2005 to guide them in rendering relevant social work services to HIV-affected children and households.

Recommendation

NGOs should continue to render services to HIV-affected families and children in terms of the Children's Act of 2005 and to keep abreast of adjustments to the Act.

7.3.6.2 Social Assistance Act No. 13 of 2004

Findings reveal that almost all the social workers were familiar with the Social Assistance Act No. 13 of 2004.

Conclusion

The fact that almost all the social workers were familiar with the Social Assistance Act No. 13 of 2004 is a clear indication that the consequences of HIV for HIV-affected households are related to ill health which results in unemployment which allows HIV-affected households to qualify for social assistance in accordance with their needs.

Recommendation

NGOs should continue to render services to HIV-affected households in terms of the Social Assistance Act and keep abreast with adjustments to the Act.

7.3.6.3 HIV and AIDS STI Strategic Plan

Findings of this study revealed that half of the social workers were familiar with the HIV and AIDS STI Strategic Plan and the other half was not familiar with the HIV and AIDS STI Strategic Plan.

Conclusion

The fact that half of the social workers who render social work services to HIV-affected households were not familiar with the HIV and AIDS STI Strategic Plan is of concern as the latter is a national guideline on various steps to be taken in order to adequately deal with the HIV epidemic.

Recommendations

It should be mandatory for all social workers irrespective of where they are employed to be familiar with the HIV and AIDS STI Strategic Plan to enable them to deal with the consequences of HIV and Aids.

7.3.6.4 Other policies and legislation

The findings of this study revealed that just less than half of the participants were not familiar with all other policies and legislation such as the Constitution of the Republic of South Africa (1996), the White Paper on Families in South Africa (2012), the Integrated Service Delivery Model (RSA, 2006), the White Paper for Social Welfare (1997) and the Framework for Social Welfare Services (2013).

Conclusions

The fact that such a large number of the participants were not familiar with policies and legislation of relevance to the social work profession is of great concern. These policies and legislation are part of social work practice. The fact that the majority of the social workers who render social work services to HIV-affected children and households already have one to three years' work experience and yet are not familiar with these policies and legislation is also a matter of concern.

Recommendation

The Department of Social Development and NGOs should, in collaboration with universities, arrange Continuous Professional Development (CPD) workshops or training for social workers on policies and legislation to equip them with knowledge of relevant policies and legislation in order to upgrade their social work intervention skills and service delivery.

7.4 SOCIAL WORK SERVICES RENDERED BY NGOS TO HOUSEHOLDS AFFECTED BY HIV AND AIDS

Findings showed that social work services rendered by NGOs to HIV-affected children and households include prevention, early intervention, statutory, residential/ alternative care and after care services. In addition, these services are rendered at micro, meso and macro levels of intervention within the context of the ecological perspective.

7.4.1 Theme 7: Prevention and early intervention services

Findings demonstrate that social work services to HIV and Aids-affected children and households include prevention and early intervention, statutory, residential and reconstruction/reunification and after care services that are rendered at various levels of

intervention such as the micro level, meso level and macro level of the ecological perspective (Bronfenbremer, 2005:37).

Various sub-themes and categories emerged from each theme and related sub-themes.

7.4.7.1 Sub-theme 1: HIV Prevention in general

Findings indicate that all the social workers at the various NGOs rendered HIV prevention services to HIV-affected households. The categories related to social work intervention at both micro level and meso level of intervention include counselling and education, and awareness of safe sex at the macro level of intervention in terms of the ecological perspective.

7.4.7.1.1 Category: Micro level: Counselling and education

Findings showed that all social workers at the NGOs provided HIV counselling and education services to individuals and couples in order to prevent HIV transmission.

Conclusion

This finding is in line with the National HIV Counselling and Testing Policy Guidelines (2010) which confirm that the HIV counselling processes entail providing information to those who intend to take or are offered an HIV test and that social workers took the roles of teacher and enabler was evident.

7.4.7.1.2 Category: Meso level: Counselling and education

Findings indicate that meso-level intervention was often practised with children in groups, with couples and with pregnant mothers with specific focus on group counselling and education.

Conclusion

As with individual counselling, the focus of intervention at this level mainly involves counselling and education in groups and with couples and the performance of the role of educator and enabler.

7.4.7.1.3 Category: Macro level: Awareness of safe sex

Findings demonstrated that awareness of safe sex at this level was taught through condom demonstration and education, as well as by pamphlet distribution in order to raise awareness of HIV prevention.

Conclusions

HIV prevention in general is focused on counselling, and education by using the role of teacher and enabler in order to prevent HIV transmission for the population in general.

Recommendation

It is recommended that the social workers at NGOs should perform the role of therapist in addition to the roles of teacher and enabler for prevention services at micro, meso and macro levels.

*7.4.7.2 **Sub-theme 2: Prevention of mother-to-child transmission***

Social work services rendered by NGOs to HIV-affected households were explored and three categories, namely counselling education and treatment, education, and awareness of safe sex were identified at micro level, meso level and macro level of social work intervention.

7.4.7.2.1 Category: Micro level: Counselling education and treatment

Findings showed, in an attempt to prevent mother to child transmission social workers render individual counselling and educational services to each pregnant mother about mother to child transmission and the importance of adhering to Antiretroviral treatment.

Conclusion

Because of the high incidence of mother-to-child transmission, information on mother-to-child transmission and HIV counselling are offered to all females irrespective of their HIV status before pregnancy to allow them an opportunity to decisively decide on future pregnancy and adherence to treatment.

7.4.7.2.2 Category: Meso level: Education

The findings show that social workers provided educational sessions on mother-to-child transmission to pregnant mothers in groups at the clinics and to support groups.

Conclusion

It became evident that social workers performed the roles of educator, enabler and therapist at micro and meso level.

Recommendation

Prevention of mother-to-child transmission education offered by NGOs at micro and meso levels should not be limited to those individual pregnant mothers who attend antenatal clinics or support groups only. These information sessions should be available to all pregnant women in communities.

7.4.7.2.3 Category: Macro level: Awareness of safe sex

Findings indicated that all pregnant mothers were educated by social workers at health care clinics with regard to the importance of adhering to treatment and consistent use of condoms and were given a pamphlet to read at home regarding a healthy diet and condom use.

Conclusion

It is imperative that social workers at health care clinics emphasise awareness of safer sex for pregnant mothers in order to avoid mother-to-child transmission.

Recommendation

Social workers should raise awareness of the availability of HIV treatment offered at health care clinics to prevent mother-to-child transmission.

7.4.7.3 Sub-theme 3: Behavioural prevention methods

Findings reveal that HIV prevention also entails the utilisation of behavioural methods. The categories that were identified are education and awareness at the various levels of intervention.

7.4.7.3.1 Category: Micro level of intervention: Education

Findings show that social workers individually educated the youth about HIV transmission, the use and demonstration of the use of both male and female condoms. Girls were individually educated about their rights and were empowered to use female condoms and contraceptives.

Conclusion

The youth is the most vulnerable age group affected by HIV. Intervention at this stage is almost too late as this age group is already sexually active in most instances. The fact that only girls are educated about their rights at the micro level means that the social work intervention is not complete as the boy child is equally exposed to and vulnerable to HIV transmission in similar ways as girls.

Recommendations

Education on behavioural prevention methods offered by NGOs should be practised at an early age to be regarded as early intervention in order to change behaviour and reduce sexual transmission of HIV. Boys should be given the opportunity to be individually educated about their rights so as to empower them similarly.

7.4.7.3.2 Category: Meso level of intervention: Education

Findings indicate that social workers educated and demonstrated male and female condom use to boys, girls at primary school level and couples in groups.

Conclusion

It became evident that social workers perform the role of an educator at meso level in educating and demonstrating how to use condoms and the need to use these for safe sex to girls and boys.

Recommendation

As with social work intervention at micro level, social workers should consider rendering HIV behavioural educational services to children at primary school level when age appropriate.

7.4.7.3.3 Category: Macro level of intervention: Awareness of safe sex

Findings indicate that social work services rendered to HIV-affected households include awareness of safe sex and that the social workers distributed male and female condoms, educated girls about their rights, provided them with pamphlets to read and booklets on condom use, HIV transmission and sexually transmitted diseases.

Conclusion

Social work intervention at macro level is focused on girls, which is in line with the National Strategic Plan (NSP, 2011-2016) stating that behavioural prevention methods of intervention should focus on young people, specifically on women. Boys or young males are not mentioned in terms of behavioral prevention education. The latter is also in contrast with their client base which requires that services are rendered to both boys and girls. Similar to the findings about education at meso level, it is evident that the role of an educator is performed at both meso and macro level to teach the community about safe sex and the need to use condoms.

Recommendation

It is recommended that NGOs should conduct research on the success of their prevention intervention programmes with boys and girls, and to determine the appropriate age for educating children about behavioural prevention methods of HIV transmission.

7.4.8 Theme 8: Statutory, Residential and Alternative care

Various forms of care and support are available to HIV-affected children and households in order to alleviate the consequences experienced with regard to HIV. This requires social work intervention in order to facilitate the process of various needed alternative placements. Findings yielded three sub-themes that may alleviate some of the consequences of HIV for affected households through providing them with care and support services. These include statutory services, residential services and alternative care. Various categories emerged.

7.4.8.1 Sub-theme 1: Micro level Intervention: Statutory Services

The first sub-theme to emerge from findings was that of services rendered by a designated social worker that involved legal processes in order to assess the need for alternative placements of children in need of care. Two categories emerged under this sub-theme, namely involvement

in children's court enquiries in terms of the Children's Act No. 38 of 2005 and involvement in temporary safe care services.

7.4.8.1.1 Category: Involvement in children's court enquiries in terms of the Children's Act No. 38 of 2005

The findings show that all of the social workers who rendered services at the various NGOs were not involved in children's court enquiries. Therefore they are not rendering statutory services and all court enquiries were directed to a designated social worker at an NGO registered as a designated child protection organisation, as defined in the Children's Act No. 38 of 2005.

Conclusion

This finding corresponds with the Children's Act indicating that it is the role of a designated social worker to conduct an investigation to assess the need for care and protection of children in need of care and then to bring the matter to the children's court.

Recommendation

Children's court enquiries should be conducted by a designated social worker, as stipulated in the Children's Act.

7.4.8.1.2 Category: Involvement in temporary safe care services

The findings indicate that some social workers did not render temporary safe care services at a micro level as some of the NGOs are not registered as a temporary safe care facility. The few NGOs that are registered as temporary safe care facilities also do not render temporary safe care services as the placement is done by a designated social worker at an NGO registered as a designated child protection organisation, as defined in the Children Act No. 38 of 2005.

Conclusion

Although some NGOs are registered as temporary safe care facilities children are placed at these facilities by designated social workers and social workers in this study then provide supervisory services, but they are not doing the actual alternative care placement.

7.4.8.2 Sub-theme 2: Macro-level intervention: Residential care

The second sub-theme that emerged from the findings was that of social worker services rendered in order to deal with the various consequences of HIV and Aids, such as psychological support and shelter needs, in order to render care and support services to HIV-affected households. The three categories that emerged were that of involvement in residential care facilities, involvement in group homes, and registration as a Child and Youth Care Centre.

7.4.8.2.1 Category: Involvement in residential care facilities

Findings reveal that some NGOs are registered as residential care services and render care and support services to HIV-affected households and some are not registered as residential care facilities. The latter, however, do provide reports on request to designated social workers who have placed children in residential care.

Conclusion

Only a few NGOs in the study were registered as residential care facilities and the majority were not. They were not totally distanced, however, as they did assist designated social workers with required reports and also rendered care and support services to children placed at the residential care facilities of their NGOs.

Recommendation

It is recommended that, although only a designated social worker is allowed to conduct a children's court investigation and to recommend an alternative placement based on the needs of the HIV-affected household, NGOs registered as residential care facilities can offer support services to children in their residential care facilities.

7.4.8.2.2 Category: Involvement in group homes

Group homes are essential for those children who are orphaned or are living in environments that prevent them from normal family functioning. There are various cluster foster care homes in the communities and social workers at NGOs in this study did render support and care services to these children and also emotional support to the carers through training in order to equip them to deal with the children. However, they did refer children to the designated social worker to act in cases where children required group home placement.

Conclusions

Group homes are situated in the communities and placements are organised by designated social workers, but care and support services are rendered by social workers at other NGOs to both the children and the carers.

Recommendation

It is recommended that, although only a designated social worker is allowed to conduct a children's court investigation and to recommend an alternative placement based on the needs of the HIV-affected household, NGOs registered as group homes can offer support services to children in their group homes.

7.4.8.2.3 Category: Registration as Child and Youth Care Centres

A few social workers indicated that they were employed by a CYCC and received referrals for HIV-affected children from the Department of Social Development to assist children in CYCC and provide reports to the Department of Social Development as needed, but they were not involved in arranging placements for these children. Although the majority of the social workers were not rendering services at registered CYCCs, they did assist children with moral support when the child needed to go to court with a designated social worker.

Conclusion

Some NGOs are registered as Child and Youth Care Centres and do render support services to HIV-affected children at these centres. However, the social workers were not involved in doing the necessary placement arrangements. The majority of the participants were not employed by a CYCC; but did render moral support to the child when the child needed to attend children's court procedures with a designated social worker.

Recommendation

Social workers should continue rendering moral support services to children who attend children's court procedures with designated social workers.

7.4.8.3 Sub-theme 3: Alternative care

Alternative care is another form of care and support rendered to HIV-affected children and households affected by the consequences of HIV and Aids and which require legal intervention. Two categories were identified, namely foster care and adoption.

7.4.8.3.1 Category: Foster care placements

Foster care placements represent the most popular form of alternative care in South Africa for caring for and protecting children whose parents have died or are not able to care for them due to unfavourable conditions.

Findings indicate that social workers at NGOs were rendering social work services to children that are placed in foster care, provided training to foster parents and recruited prospective foster parents. They also provided designated social workers with reports on request. However, social workers at NGOs were not involved in the process of placement, only the designated social worker.

Conclusion

As recommended in the Children's Act No. 38 of 2005, only designated social workers are required to do foster care placement as they do the home circumstances investigation. The role of the designated social worker is continuously mentioned throughout the findings under the theme of statutory, residential and after care. This is because only designated social workers can be involved in court-related procedures and involved in court ordered services.

Recommendation

NGOs rendering services to HIV and Aids-affected households should cooperate with designated social workers to meet the needs of children from HIV-affected families in need of care and protection.

7.4.8.3.2 Adoptions

Findings indicate that social workers were not involved in adoption placements. However, the social workers educated people who inquired about adoption and referred them to the various adoption centres. The findings also reveal that people are often reluctant to adopt HIV-positive

children or children from a different clan group than theirs; unless it is a family member's child and they will just take the child.

Conclusion

HIV-affected babies or children are similarly in need of adoption like all vulnerable children. However, their HIV status appears to be a barrier to adoption.

Recommendations

NGOs should conduct research to ascertain the number of adopted HIV-infected children, their relationship with the adoptive parents, and the reasons for adoption.

NGOs should address aspects of stigma and discrimination as it deprives HIV-affected babies and children of alternative care such as adoption.

7.4.9 Theme 9: Reconstruction/ Reunification and Aftercare Services

Aftercare services are supportive services that are rendered by social workers at NGOs after discharge of a child from a residential facility or reunification of the child with his or her parents after the placement in order to monitor and evaluate the adjustment of the child to the social circumstances of the HIV-affected household. The latter requires various social work service interventions in order to assure adequate care and support after reunification. Findings yielded two sub-themes, namely aftercare services and after-school care services.

7.4.9.1 Sub-theme: Aftercare services

The first sub-theme to emerge from the findings was that of the provision of continuous care and support services to HIV-affected children and households in order to ensure optimal care. Only one category emerged under this sub-theme, namely provision of community-based care services.

7.4.9.1.1 Category: Provision of community based care services

Community-based care services are essential in rendering the needed services required by HIV-affected children and households after discharge from alternative care or reunification with the family. The majority of the social workers mentioned that they did have trained community-based care workers that provided aftercare services such as monitoring both TB and

Antiretroviral treatment, as well as assisting HIV-infected parents with bathing and fetching their medication at the clinic. A few social workers mentioned that they referred HIV-affected children or households to the clinics in order to access community-based care services. They however did not provide reunification services themselves.

Conclusion

Community-based care services are essential for maintaining continuity of service delivery after the discharge of a child from an alternative placement.

Recommendations

NGOs should continue training community-based carers to render aftercare services to HIV-affected households.

7.4.9.2 Sub-theme: After-school care services

After-school services are essential for HIV-affected children and households to ensure optimal care and protection and to ensure that their welfare needs are met. Several categories emerged under this sub-theme, namely provision of meals to children, provision of homework assistance, provision of school holidays and safety programmes, provision of support and income-generating groups, and provision of home visiting services.

7.4.9.2.1 Category: Provision of meals to children

Food is one of the basic needs of all children as stated in the South African Constitution (1996). However the lack of adequate food has been identified as one of the consequences experienced by HIV-affected children and households. Social workers at NGOs indicated that they provided meals for children and families through their daily feeding programmes that were supplemented by bakeries and vegetable gardens maintained by some beneficiaries of services rendered by NGOs.

Conclusion

This finding corresponds to the mission of the various NGOs, which concerns alleviating poverty.

Recommendation

NGOs should offer feeding programmes to make meals available to HIV-affected children and households to which they render services on a daily basis.

7.4.9.2.2 Category: Provision of homework assistance

Early dropout from school and not attending school were identified as consequences facing HIV-affected children and households.

Findings indicate that volunteers, retired teachers from local communities and abroad, as well as some gap year learners assisted HIV-affected children with homework, reading skills and activities to stimulate the brain.

Conclusion

Homework assistance is normally offered after school and the focus is not only on homework, but also allow the children an opportunity to engage in other activities in line with the United Convention of the Rights of the Child (1989) that state that children need to be given the opportunity to participate in recreational activities.

Recommendation

NGOs should continue rendering homework assistance and recreational activities to children from HIV-affected households.

7.4.9.2.3 Category: Provision of school holidays and safety programmes

Findings show that safety programmes dealing with as sexual abuse and how to react to strangers at home and in public places were made available to all children in the communities during school holidays and that they were taken on educational excursions.

Conclusion

School holiday and safety programmes are informative in terms of educating the children about safety measures, as well as for enjoying practical educational exposure and recreation.

7.4.9.2.4 Category: Provision of support and income-generating groups

Support groups are ideal for HIV-affected children and households as this allows emotional and physical support from peers in the group. It also allows an opportunity for personal development through learning. The findings reveal that various support groups were available to HIV-affected households. These were support groups for unemployed women who did not qualify for grants, to equip them with sewing and beading skills in order to develop employment skills, a gardening skills project for any community member to enable them to follow a nutritious affordable diet, as well as a support group for HIV-affected children, adults and families in which adherence and emotional issues are addressed.

Conclusion

The various support groups were directed towards HIV-affected households. However, support in terms of skills development was also available to the community at large and was also aimed at supporting the community at large, as stipulated in the mission statements of the various NGOs.

Recommendation

NGOs should establish support groups or programmes such as skills development for all members in communities as they are poor and equally endure challenges similar to what is posed by the consequences of HIV to affected households.

7.4.9.2.5 Category: Provision of home visiting services

Home visiting also presents a continuum of care services provided by NGOs to HIV affected households in order to ensure that practical assistance is offered as required by HIV-affected households as well as to investigate the social circumstances at the home.

Findings indicate that home visit were conducted to ascertain whether HIV-affected households complied with their treatment; to offer continuous support or food and means to meet other material needs, as well as ascertaining the need to be referred back to a programme relevant to their needs when needed.

Conclusion

Aftercare services are often availed to HIV-affected households on the continuum of care and support services in terms of the ISDM (2006) after discharge from an alternative care placement or from a specific programme in order to ensure optimal functioning.

Recommendation

NGOs should render home visiting services in terms of the ISDM (2006) to HIV and Aids-affected households.

7.5 RECOMMENDATIONS FOR FURTHER RESEARCH

There is much potential for future research on topics related to services rendered by NGOs to HIV-affected households. This study with its exploratory and descriptive designs makes a novel contribution to enhance understanding of social services rendered by NGOs to HIV-affected household. The results of the study in part echo and are corroborated by existing literature on the subject of HIV. What is novel about it is that it brings together previously disconnected findings and theory in a single study and does so from a social work perspective.

The following areas could be investigated in further research:

- The extent to which the roles performed by NGO social workers could be extended to include therapeutic, broker and advocate roles for intervention in terms of the ISDM (2006) and the Framework for Social Welfare Services (2013).
- Government's role in responding to the needs of orphaned children in child-headed households in terms of policies and legislation to uphold these children's rights.
- The availability and improvement of temporary and permanent residential care facilities for HIV-affected children and households.
- Social work services rendered to male persons in HIV-affected households in terms of involving them in the care and support of the household.

7.6 CONCLUSION

This chapter achieved the final objective of the study from an ecological perspective. Conclusions were drawn and recommendations are made based on empirical findings on the

nature and extent of existing social work services rendered to HIV-affected children and households by social workers in various NGOs in the Cape Metropole.

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ANNEXURE A:
ETHICS CLEARANCE LETTER

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

NOTICE OF APPROVAL

REC: SBER - Initial Application Form

15 May 2019

Project number: 0510

Project Title: social work services offered by non governmental organisations to households affected by HIV and AIDS

Dear Miss Nocawe Frans

Your REC: SBER - Initial Application Form submitted on **09 May 2019** was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
10 November 2017	09 November 2020

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number **(0510)** on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Research Protocol/Proposal	chapter 1 Nov 2014	05/07/2017	
Informed Consent Form	consent letters	10/07/2017	
Data collection tool	interview themes	10/07/2017	
Default	Consent doc	03/05/2019	
Default	QUESTIONNAIRE	03/05/2019	
Data collection tool	QUESTIONNAIRE	03/05/2019	
Proof of permission	Consent doc	03/05/2019	final
Data collection tool	QUESTIONNAIRE	03/05/2019	final
Default	informed consent template	06/05/2019	final
Default	DESC_REC_RESPONSE LETTER	06/05/2019	final
Default	CV	06/05/2019	final

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents/process, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9.Final reports. When you have completed (no further participant enrollment, interactions or interventions) or stopped work on your research, you must submit a Final Report to the REC.

10.On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

ANNEXURE B:
CONSENT FROM ORGANISATIONS

Nocawe Frans

From: Zikhona Dingaan <zikhona.dingaan@gmail.com>
Sent: 22 August 2017 12:02 PM
To: Nocawe Frans
Subject: Re: FW:
Attachments: MS NOCAWEFRANS.pdf

Good morning Ms Frans

I trust you are well.Allow me to apologise for sending the letter now.We have a problem with internet.I logged in by luck even now.I have been worried about the letter.Kindly receive it below FYI.

Warm Regards
Zikhona Dingaan

On Fri, Aug 18, 2017 at 1:43 PM, Nocawe Frans <Nocawe.Frans@westerncape.gov.za> wrote:

Dear Zikhona

Our telephonic discussion on 17/08/2017 refers

I am Nocawe Frans currently doing my PHD in social work at the University of Stellenbosch as well as asocial work supervisor at Tygerberg Hospital. In 2014 I was given permission to conduct my research at your organization (see attached permission letter). The topic of my research study is " social work services offered by NGOs to households affected by HIV and AIDS"

I am currently busy with my last chapter of my literature review, with the intentions to commence with the research in 2018. It is now requested by the Ethics Committee at the University of Stellenbosch that the dates be adjusted to the current year please.

Thank you for your support.

Kind regards

Nocawe

SIZAKUYENZA
We will do it!
043-672 NPO

Sizakuyenza

Cnr of New Eisleben & Mpumelelo Road

Philippi

18 August 2017

The Faculty Head

Dept. of Social Sciences

University of Stellenbosch

Stellenbosch

TO WHOM IT MAY CONCERN

This is to confirm that Ms Nocawe Frans has approached us to conduct her PHD research at Sizakuyenza HIV/AIDS Programme.

This research is focused on services offered to families/households affected by HIV/AIDS, and entail interviews of staff, Social Worker, and Management team. Permission is granted for her to proceed with such research as envisaged.

Yours Sincerely

Zikhona Dingaan

Social Worker

SIZAKUYENZA
Reg. n. 043 672 NPO
Khanyisa Community Centre
Philippi, Cape Town

Khanyisa Community Centre, Casa del Sorriso – New Eisleben Rd – Philippi – Cape Town
Tel: 021 374 0800

To: Didi Engelbrecht <didi@yabonga.com>
Subject: RE: Permission to conduct research

Dear Didi

See attached.

Thank you for your time, see attached. I need not to have an agency supervisor as I will only spend a day at the agency as will only interview two people a social worker and a manager.

Kind regards
Nocawe

From: Didi Engelbrecht [mailto:didi@yabonga.com]
Sent: 22 August 2017 10:36 AM
To: Nocawe Frans
Cc: Ulpha Robertson
Subject: Permission to conduct research

Dear Nocawe, our telephone conversation this morning hereby refers.

As indicated, consideration is being given to your request. Please kindly send us a copy of your Proposal you submitted in 2014, to view.

Then, we would also like to know if your Agency Supervisor- is required to be a Social Worker.

Thanks & Regards.

Didi Engelbrecht
General Manager

2 Main Road, Wynberg, 7800
Tel: + 27 21 761 2940 Fax: +27 21 761 3407
Cell: +27 73 194 5168 E-mail: didi@yabonga.com

YABONGA
Children, HIV and AIDS
www.yabonga.com

From: **Nocawe Frans** <Nocawe.Frans@westerncape.gov.za>
Date: Thu, Aug 17, 2017 at 1:10 PM
Subject: Permission to conduct research
To: "Info Yabonga (info@yabonga.com)" <info@yabonga.com>

Good day BiBi

I am Nocawe Frans currently doing my PHD in social work at the University of Stellenbosch as well as asocial work supervisor at Tygerberg Hospital. In 2014 I was given permission to conduct my research at your organization (see attached permission letter). The topic of my research study is " social work services offered by NGOs to households affected by HIV and AIDS"

I am currently busy with my last chapter of my literature review, with the intentions to commence with the research in 2018. It is now requested by the Ethics Committee at the University of Stellenbosch that the dates be adjusted to the current year.

Kindly indicate if you will need to go through my proposal.

Thank you for your support.

Kind regards

Nocawe

2 Main Road Wynberg 7800
South Africa
Private Bag X1
Mowbray 7705
T + 27 (21) 761 2940
F + 27 (21) 761 3407
Email: info@yabonga.com

Stellenbosch University

Dear Members of the Committee,

25th August 2017

Permission granted for Ms. Nocawe Frans to do research at Yabonga

On behalf of Yabonga Children, HIV and AIDS I herewith confirm, that we are aware that Ms. Nocawe Frans intends to conduct her research with our organisation in 2018. She will be interviewing the Social Worker, as well as a member of our Management Team.

A requirement for this research however, is that Yabonga is quoted as a source in the Bibliography, and once published, this information is also shared with the organisation.

We grant Ms. Nocawe Frans permission, to conduct her research for her dissertation with us.

Yours Sincerely,

Didi Engelbrecht
General Manager

2 Main Road, Wynberg, 7800
Tel: + 27 21 761 2940 Fax: +27 21 761 3407
Cell: +27 73 194 5168 . E-mail: didi@yabonga.com

Children, HIV and AIDS
www.yabonga.com

Nocawe Frans

From: Audrey Abrahams <opsmanager@wolanani.co.za>
Sent: 07 November 2017 04:41 PM
To: Nocawe Frans
Subject: RE: PERMISSION TO CONDUCT RESEARCH

Dear Ms. Frans

Trust you well,

This mail serves to confirm that you can conduct your research at our organisation next year. As indicated you will interview our social worker, and 1 manager at our offices.

Kindly confirm receipt of this mail.

Kind Regards
Audrey Abrahams
Operations Manager
Tel: +27 21 447 2091
Fax: +27 21 447 3126
Unit 3, Block A, Collingwood Place, 9 Drake Street,
Observatory, 7925
P.O. Box 13890, Mowbray, 7705
http://www.wolanani.co.za

From: Nocawe Frans [mailto:Nocawe.Frans@westerncape.gov.za]
Sent: 23 October 2017 01:18 PM
To: opsmanager@wolanani.co.za
Subject: FW: PERMISSION TO CONDUCT RESEARCH

Good day Ms Abrahams

Please see below, any response please.

Kind regards
Nocawe

From: Nocawe Frans
Sent: 20 September 2017 03:27 PM
To: opsmanager@wolanani.co.za
Subject: PERMISSION TO CONDUCT RESEARCH

Good day Ms Abrahams

I am Nocawe Frans currently doing my PHD in social work at the University of Stellenbosch as well as a social work supervisor at Tygerberg Hospital. I started to work at Tygerberg Hospital in 1995 to date and was rendering social work services to HIV and AIDS families and closely liaise with NGO'S that renders services to HIV and AIDS. The topic of my research study is " social work services offered by NGOs to households affected by HIV and AIDS"

I hereby request permission to conduct my research at your organisation in 2018. I will be interviewing a social worker as well as a member of management. I will only spend a few hours at the agency depending on the availability of the social worker and the manager. Kindly indicate if you need to have a copy of my proposal.

I trust my request will meet your favourable consideration.

Hope to hear from you soon.

Kind regards

Nocawe

Nocawe Frans

From: Audrey Abrahams <opsmanager@wolanani.co.za>
Sent: 07 November 2017 04:41 PM
To: Nocawe Frans
Subject: RE: PERMISSION TO CONDUCT RESEARCH

Dear Ms. Frans

Trust you well,

This mail serves to confirm that you can conduct your research at our organisation next year. As indicated you will interview our social worker, and 1 manager at our offices.

Kindly confirm receipt of this mail.

Kind Regards
Audrey Abrahams
Operations Manager
Tel: +27 21 447 2091
Fax: +27 21 447 3126
Unit 3, Block A, Collingwood Place, 9 Drake Street,
Observatory, 7925
P.O. Box 13890, Mowbray, 7705
http://www.wolanani.co.za

Nocawe Frans

From: Busisiwe Treasure OBose <obose.practice@gmail.com>
Sent: 25 August 2017 03:51 PM
To: Nocawe Frans
Subject: Re: Research permission

Good afternoon Ms. Frans,

I am struggling to reformat the Baphumelele letter above, because its in PDF file, my junior Social Workers, who would be most familiar with technology have already left. Can i pleeease send you a curent version of this, in terms of date and signatory on Monday, 1st thing in the morning on Monday, 28th August 2017. Please accept my apologies for the delay and inconvenience.

Warm Regards,

Busisiwe OBose

On Fri, Aug 18, 2017 at 1:32 PM, Nocawe Frans <Nocawe.Frans@westerncape.gov.za> wrote:

Good day Busisiwe

Our telephonic discussion refers

I am Nocawe Frans currently doing my PHD in social work at the University of Stellenbosch as well as a social work supervisor at Tygerberg Hospital. In 2014 I was given permission to conduct my research at your organization (see attached permission letter). The topic of my research study is " social work services offered by NGOs to households affected by HIV and AIDS"

I am currently busy with my last chapter of my literature review, with the intentions to commence with the research in 2018. It is now requested by the Ethics Committee at the University of Stellenbosch that the dates be adjusted to the current year.

Thank you for your support.

Kind regards

Nocawe

BAPHUMELELE
CHILDRENS HOME

7 September 2017

Dear Members of the committee

Please note that I acknowledge that I am aware that Ms. Nocawe Frans intends to conduct research on **social work services offered by NGO's to household affected by HIV/AIDS.** We are a residential facility providing care for children infected and affected by HIV/AIDS.

I understand that she will be interviewing the social worker at our NGO and if available a member from management.

I give Ms. Nocawe Frans permission to conduct the research at Baphumelele.

Sincerely

Busisiwe OBose
Senior Social Worker
Baphumelele Waldorf Association
Tel: + 27(0) 21 361 8631

BAPHUMELELE WALDORF (ASSOCIATION UNDER SECTION 21)
7 118 Dabula Street, Khayelitsha 7784, South Africa, ☎ +27 (0)21 361 8631, fax +27 (0)21 361 2695
www.baphumelele.org.za / info@baphumelele.org.za

Section 21 Registration Number - 1995/007799/08
Department of Social Services and Poverty Alleviation - Reg. No. 1551122 C7531
Public Benefit Organization (PBO) Reference Number: 930019697
Nonprofit (NPO) Reference Number: 051-418

Nocawe Frans

From: Eunice Pretorius <sw@heartlandsbaby.org>
Sent: 18 August 2017 07:43 AM
To: Nocawe Frans
Subject: RE: Permission to conduct research
Attachments: Heartlands permission for research Nocawe Frans.pdf

Good morning Nocawe

Please find attached the **document confirming permission to conduct your research** at Heartlands baby sanctuary. Would you kindly inform me if this is correct?

I am looking forward to meeting you in the near future.

Kind regards

Eunice Pretorius
Social Worker
Tel: 021 852 3527
Cell: 072 282 5815
Website: www.heartlandsbaby.org

From: Nocawe Frans [mailto:Nocawe.Frans@westerncape.gov.za]
Sent: 17 August 2017 03:40 PM
To: sw@heartlandsbaby.org
Subject: Permission to conduct research

Dear Eunice

Our telephonic discussion refers.
I am currently doing my PHD in social work at the University of Stellenbosch as well as a social work supervisor at Tygerberg Hospital. In 2014 I was given permission to conduct my research at your organization (then Cotlands see attached permission letter). The topic of my research study is " social work services offered by NGOs to households affected by HIV and AIDS"
I am currently busy with my last chapter of my literature review, with the intentions to commence with the research in 2018. It is now requested by the Ethics Committee at the University of Stellenbosch that the date as well as the contact details be adjusted to the current year.

Thank you for your support.

Kind regards
Nocawe Frans

Heartlands
baby sanctuary
it's every child's birthright to belong

18 August 2017

Dear members of the committee (Social Work Department)

On behalf of Heartlands baby sanctuary we are aware that Ms Nocawe Frans intends to conduct her research on ***social work services offered by NGO's to households affected by HIV/AIDS*** by interviewing the social worker at our NGO, including a member from management.

The management therefor gives Ms Nocawe Frans permission to conduct the research at Heartlands baby sanctuary.

Kind regards

Eunice Pretorius
Manager: Psychosocial Services
Social Worker Registration number: 1038414

NPO: 165 922 | Heartlands Baby Sanctuary | Tel: 021 852 3527 | Fax: 021 852 9327 |
Post: P.O. Box 3337, Somerset West, 7129 | Address: 794 Old Paardevlei road, The Interchange, Somerset West, 7130
www.heartlands.org

like her to update this letter (attached) confirming that she is able to do her research with Noxolo at a date to be confirmed.

I would be most appreciative if you could respond to Nocawe as soon as possible please and copy me in on the mail.

Manythanks and all good wishes.
Val

From: Nocawe Frans [mailto:Nocawe.Frans@westerncape.gov.za]
Sent: 18 August 2017 01:58 PM
To: val@intermail.co.za
Subject: Research permission

Good day Ms Barry

Our telephonic discussion on 18/08/2017 refers

I am Nocawe Frans currently doing my PHD in social work at the University of Stellenbosch as well as a social work supervisor at Tygerberg Hospital. In 2014 I was given permission to conduct my research at your organization (see attached permission letter). The topic of my research study is " social work services offered by NGOs to households affected by HIV and AIDS"
I am currently busy with my last chapter of my literature review, with the intentions to commence with the research in 2018. It is now requested by the Ethics Committee at the University of Stellenbosch that the organisations details be updated please, such as the date and signature.

Thank you for your support.

Kind regards
Nocawe

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etafeni day care centre trust

Telephone +27(0)21 386 1516 *Fax* +27 (0)21 386 2560

working together to promote wellbeing, breaking the cycle of poverty and creating positive change

30 August 2017

Dear Members of the committee

RE: Permission to Ms. Nocawe Frans to conduct research at Etafeni.

On behalf of Etafeni we are aware that Ms. Nocawe Frans intends to conduct her research on social work services offered by NGO's to household affected by HIV/AIDS by interviewing the social worker/s at our NG including a member from management. I therefore give Ms. Nocawe Frans permission to conduct the research at Etafeni.

Patrick Andries

Director

at the open space ...

Sihume Road Nyanga 7750 Western Cape South Africa | www.etafeni.org

ACTING PROJECT MANAGER/DEVELOPMENT MANAGER

Phone +27 (0)82 890 2555 *Email* barbara@etafeni.org.za

024-270-NPO

home from home
Building a better future for children in need

25 August 2017

Dear members of the committee

On behalf of Home from Home, we are aware that Ms Noncawe Frans intends to conduct her research by interviewing the 4 social workers at our NGO, including a member of management. We hereby grant Ms Frans persmission to conduct her interviews at Home from Home.

With gratitude,

Jane Payne

Programme Director

P O Box 18237, Wynberg Cape Town, South Africa Tel: +2721 761 7251 * Fax: +2721 7611581
E-mail: info@homefromhome.org.za Website: www.homefromhome.org.za

PBO 93100118033, NPO 053-721, TRUST NO. 11/1496/2005, Section 18A Approved

Nocawe Frans

From: Nocawe Frans
Sent: 15 March 2018 02:53 PM
To: 'Jane Payne'
Subject: RE: INTERVIEWS (POSSIBLE DATE FOR 1ST WEEK IN APRIL 2018)

Hello
Thank you Jane. It is ok, Let it then be a pilot study. 3rd will be ok at 10:00. Looking forward to see after such a long time.
Thanks
Nocawe

From: Jane Payne [mailto:Jane@homefromhome.org.za]
Sent: 15 March 2018 02:34 PM
To: Nocawe Frans
Subject: RE: INTERVIEWS (POSSIBLE DATE FOR 1ST WEEK IN APRIL 2018)

Thanks I am not sure we will be able to answer some of your questions as we are not involved with HIV/ AIDS policies etc. our emphasis and expertise has always been the care of children in foster care and not HIV..
I hope we will be able to help you but I don't want you to waste time if we can't really assist your research.
I am happy to meet you anyway would 3rd April at 10:00 suit you ?

Thanks
Jane

From: Nocawe Frans [mailto:Nocawe.Frans@westerncape.gov.za]
Sent: Thursday, March 15, 2018 2:17 PM
To: Jane Payne
Subject: INTERVIEWS (POSSIBLE DATE FOR 1ST WEEK IN APRIL 2018)

Good day Jane

Thank you for your willingness to participant in my research study. I intend to conduct the research on any day and time during the first week of April (if possible). I need to interview 2 social workers (that is you and 1 more Socialworker). I am not sure as yet as to how long the interview will take, but it should not be more than an hour.

It will be a semi-structured interview and the participant will be audio- taped. The questions will be based on how affected households experiences the consequences of HIV and AIDS such as: their survival and care needs, emotional needs, health care needs, economic needs e.t.c. Policy and legislation related to affected households such as The Constitution of the RSA, Children's Act, ISDM, The Frame Work for social work intervention, HIV and AIDS Strategic Plan and many more (just an idea as to how it guides you in addressing the needs of affected households) . The Ecological Perspective and its levels of intervention like micro, mezzo and macro. Social work services rendered in prevention and early intervention, statutory, residential and early intervention, reconstruction and after care.

I will also provide you with the questionnaire on arrival.

Thank you
Nocawe

Nocawe Frans

From: Nocawe Frans
Sent: 31 August 2017 08:46 AM
To: umthawelanga@kingsley.co.za
Subject: permission to conduct research
Attachments: umthawelanga.pdf

Good morning Vivienne

Hope you are well. See attached consent letter that I received from your organization to conduct research in 2014. I am currently busy with my final literature chapter, and will be able to conduct my research in 2018. It is now requested by the Ethics committee at the University of Stellenbosch that the dates on the consent form be adjusted to the current year. Will you please be so kind to resign the attached consent form and adjust the date please.

Hope to hear from you soon.

Kind regards
Nocawe

Umtha Welanga HIV/AIDS AND
FOSTER PLACEMENTS NPC
2011/134991/08 T/A Umtha Welanga NPO 025-321
Masiphulisane Centre
E 505 Scott Street
P O Box 16
Khayelitsha 7784

Phone - 27 21 8288099-0834257819
E-Mail- umthawelanga@kingsley.co.za

05/09/2017

Dear Member of the Committee

Trust that all is well, I am writing on be behalf of Umtha Welanga Organization as we excepted Ms Nocawe Frans in 2014 to conduct her research interviewing the social worker and member of the management and this could not take place therefore we are excepting/ give her permission to continue with her study as from next year 2018 she will let us know the date and the month as time comes .

Yours in community development

Vivienne Mciteka (Director)

ANNEXURE C:
INFORMED CONSENT LETTER FROM SERVICE PROVIDERS

ANNEXURE C

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH: MANAGERS

SOCIAL WORK SERVICES OFFERED BY NON-GOVERNMENTAL ORGANISATIONs TO HOUSEHOLDS AFFECTED BY HIV and AIDS

You are hereby kindly requested to participate in a research study which is to be conducted under the auspices of the Department of Social Work at the University of Stellenbosch. This research will be undertaken by Ms Nocawe Frans in order to fulfil the requirements of a doctoral degree in social work. The results of this study will be published in a research report. You were identified as a potential participant in this study because you are a social worker in a non-governmental organisation.

1. PURPOSE OF THE STUDY

The aim of the study is to gain a deeper understanding of social work services rendered by social workers to households affected by the human immunodeficiency virus (HIV) as well as acquired immunodeficiency syndrome (AIDS). The study will be conducted within the social development paradigm.

2. PROCEDURES

Should you choose to become a part of this research study, you will be requested to participate in a semi-structured interview. All information gathered during this interview will remain strictly confidential. You will be under no obligation to indicate your name or any particulars on the interview schedule. All interviews will be conducted by the doctoral student in question.

3. POTENTIAL RISKS AND DISCOMFORTS

You are encouraged to discuss any uncertainties you may harbour about with the interview schedule or process with the researcher at any time.

4. POTENTIAL BENEFITS TO SUBJECTS AND / OR TO SOCIETY

The results of this study will provide non-governmental organisations with a better understanding of how social work services are rendered to HIV/AIDS affected households within a social development paradigm. This information could be used by non-governmental organisations for further planning in service delivery.

5. PAYMENT FOR PARTICIPATION

Participants will not receive any form of payment for their participation in this study.

6. CONFIDENTIALITY

Any information obtained during the course of this research will remain confidential and will be disclosed only with your permission or as required by law. All questionnaires will be managed, analysed and processed by the researcher and will be stored in a secure location.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether or not to participate in this study. Should you volunteer to be a respondent in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer, and still remain a participant in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so (for example, if you should influence other participants in the completion of their questionnaires).

8. IDENTIFICATION OF STUDENT-RESEARCHER

If you have any questions or concerns about the research, please feel free to contact the study supervisor, Professor Sulina Green, at the Department of Social Work at the University of Stellenbosch. Her contact details are as follows:

Telephone: 021-808 2070
Email: sgreen@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation in this study without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, please feel free to contact Ms Maléne Fouché of the Stellenbosch University's Division for Research Development. Her contact details are as follows:

Telephone: 021 808 4622
Email: mfouche@sun.ac.za

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

I, the participant, _____, hereby declare that all of the information contained in this document, as well as any other information relevant to me as a participant in this study, was clearly and comprehensively communicated to me by the researcher, Ms Nocawe Frans. I declare that I am satisfied with and fully comprehend said information. I declare that I was afforded the opportunity to ask any and all questions about the study that I deemed necessary, and that these questions were answered to my satisfaction.

I hereby voluntarily consent to participate in this study.

_____

Name of Participant

_____ _____

Signature of Participant **Date**

SIGNATURE OF RESEARCHER

I, the researcher, _____, hereby declare that I clearly and comprehensively communicated to the participant,_____, all of the information contained in this document, as well as any other information relevant to the participant in this study. I declare that, to the best of my knowledge, the participant fully comprehends said information. I declare that I afforded the participant the opportunity to ask any and all questions about the study that he or she deemed necessary, and that, to the best of my knowledge, these questions were answered to his or her satisfaction.

This communication with the participant took place in English, and no translator was used.

_____ _____

Signature of Researcher **Date**

ANNEXURE D:
INTERVIEW SCHEDULE FOR SERVICE PROVIDERS

ANNEXURE D:

STELLENBOSCH UNIVERSITY

DEPARTMENT OF SOCIAL WORK

SEMI-STRUCTURED INTERVIEW SCHEDULE

SOCIAL WORK SERVICES OFFERED BY NON-GOVERNMENTAL ORGANISATIONS TO HOUSEHOLDS AFFECTED BY HIV AND AIDS

Interviewer: Nocawe Frans

Please note:

- All the information recorded in this interview will be regarded as confidential
- The names of persons who participate will be kept confidential

Instructions:

- Please answer the following questions
- Please be as honest as possible

Date of interview: ..... Participant number: .....

1. Qualifications

1.1 What is your highest qualification?

- Diploma in Social Work
- B Degree in Social Work
- Honours in Social Work
- M Social Work
- PHD Social Work

1.1.1 What other qualifications or specialized training related to HIV and Aids do you possess?

2. Experience

2.1 How many years are you practising as a registered social worker?

2.2 How many years are you working in the field of HIV and Aids?

2.3 In what professional capacity are you involved in HIV and Aids welfare activities at your organization?

3. Profile of NGO

3.1 How is the NGO that you are working for registered in terms of the Act on NPOs (Act 71/1997?

3.2 What is the mission of your organisation?

3.3 Where does the organization get its funding from for service rendering to clients?

3.4 How does the organisation utilize the funding it receive to meet the mission of the organisation ?

3.5 Describe the client base that makes up the service users of this organization, in other words who are the clients that you are rendering services to?

4. Consequences of HIV and Aids

4.1 How do the affected households that you are rendering services to experience the consequences of HIV and Aids with regards to:

4.1.1 Their survival and care needs

4.1.2 Their emotional needs

4.1.3 Their health care needs

4.1.4 Their educational needs

4.1.5 Their economic needs

4.1.6 Their welfare needs

5. Policy and legislation related to households affected by HIV and AIDS

5.1. Explain how the following policies and legislation are guiding your care, protection and welfare services to address the needs of HIV and AIDS affected households:

5.1.1 The Constitution of the Republic of South Africa

5.1.2 White Paper for Social Welfare

5.1.3 White Paper on Families in South Africa

5.1.4 Integrated Service Delivery Model (ISDM)

5.1.5 Framework for Social Welfare Services

5.1.6 The HIV and AIDS and STI Strategic Plan for South Africa 2012-2016

5.1.7 Children's Act 38 of 2005 and Amended Act 41 of 2007

5.1.8 Social Assistance Act (2004)

5.2 Are there any other policies or legislation that are guiding the services that you are rendering to address the needs of HIV and AIDS affected households?

6. Social work services mandated by government and offered by Non-governmental Organisations to households affected by HIV and AIDS

6.1 Nature of social work services

The purpose of this study is to find out what social work services NGOs are rendering to HIV and AIDS affected households in terms of the following two policies:

The **Integrated Service Delivery Model (ISDM) (2006)** and the **Framework for Social Welfare Services (2013)** equally recommends integrated social welfare services to be rendered to vulnerable people such as HIV and AIDS affected households which includes prevention, early intervention, statutory intervention/ residential/alternative care and reconstruction and after care in order to meet their welfare needs. **The figure below demonstrates the levels of work services described in these policies:**

Figure1. Levels of social work services

Source: (Integrated Service Delivery Model, 2006)

In addition Social work services within the context of the Ecological Perspective can be rendered at micro level (case work), messo level (group work) and macro level (community work) as can be seen from the figure below.

Figure2. Levels of Ecological Perspective

Source : Nash, O'Donoghue and Munford 2005

Against the background of these policies let us look at the services your organization offers at each of the levels. Could you also indicate how you use case work (micro practice), group work (messo practice) and community work (macro practice) in terms of the Ecological Perspective at these levels and give examples?

6.2 Social work services rendered by NGO

6.2.1 **Prevention and early intervention**

6.2.2 Describe how social work services are rendered by your organisation for HIV prevention in general

6.2.3 Describe how social work services are rendered by your organization for **prevention of mother to child transmission of HIV and Aids.**

6.2.4 Describe how your organization uses **behavioural prevention methods** such as male and female condoms and male circumcision for your clients?

6.2.5 Describe which community awareness programmes your organisation offers for prevention of HIV.

6.3 Statutory, residential and alternative care

At this level of service rendering court interventions are required to ensure the care, protection and welfare of children and carers.

6.3.1 Describe how your organisation renders the following **statutory services** to HIV affected families and children.

6.3.1.1 Children's court enquiries in terms of the Children's Act no 38 of 2005

6.3.1.2 Temporary safe care services in terms of the Children's Act no 38 of 2005.

6.3.2 Describe how your organisation is involved in the following **residential care** services to HIV affected families and children

6.3.2.1 Children's homes in terms of the Children's Act no 38 of 2005

6.3.2.2 Group homes in terms of the children's Act no 38 of 2005

6.3.3 Placement in child and youth care centres in terms of the children's Act no 38 of 2005

6.3.4 Describe how your organisation uses the following **alternative care** services for HIV affected families

6.3.4.1 Foster care placements

6.3.4.2 Adoption

6.4 Reconstruction/ Reunification and after care

7.4.1 Describe how your organisation offers the following **after care services** to HIV affected families

7.4.1.1 Reunification services

7.4.1.2 Reconstruction services

7.4. 1.3 Home visiting services

7.4.1.4 Drop in centres and support programmes

7.4.1.5 Comprehensive home based care programmes

8 General

8.1 How is it for you to render services to HIV affected households?

Thank you for your participation.